IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

IN RE: ETHICON, INC. PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION	MDL NO. 2327 Master File No. 2:12-MD-02327 JOSEPH R. GOODWIN U.S. DISRICT JUDGE
THIS DOCUMENT RELATES TO: JO HUSKEY and ALLEN HUSKEY, Plaintiffs, vs. ETHICON, INC., et al., Defendants.	Case No. 2:12-MD-05201

DEPOSITION OF ERIN T. CAREY, M.D.,

produced, sworn and examined on behalf of the Defendants pursuant to Notice, on Wednesday, the 2nd day of July, 2014, between the hours of 9:04 a.m. and 2:46 p.m. of that day, at the law offices of Wagstaff & Cartmell, 4740 Grand Avenue, Suite 300, in the City of Kansas City, in the County of Jackson, and the State of Missouri, before me, NAOLA C. VAUGHN, MO CCR 1052, KS CCR 0895, CRR, RPR, a Certified Court Reporter, within and for the States of Missouri and Kansas.

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WITNESS: ERIN T. CAREY, M.D.

EXHIBITS

(Exhibits 1 and 2 marked.)

ERIN T. CAREY, M.D.,

a witness, being first duly sworn, testified as follows:

EXAMINATION

BY MR. SNELL:

Q. State your full name for the record, please.

A. Erin Teeter Carey.

Q. You're a medical doctor?

A. I am.

Q. You understand you're here to give deposition testimony today in the Huskey matter, which is currently bending in the Federal Court in West Virginia?

A. Yes.

Q. I've marked Exhibit 1 as your notice of deposition.

Have you seen that document before?

A. I have.

Q. Okay. When did you look at that document?

A. I saw it yesterday.

Q. Exhibit 2 I've marked. Can you identify that for the record?

A. This is my rebuttal.

Q. That is your expert report in the Huskey case; correct?

A. Correct.

Q. You have issued no other reports in the Huskey case; correct?

A. I -- no. I mean, this is my rebuttal to Dr. Pradmudji.

MR. KUNTZ: I'm just giving her one that's not -- it's just one page so it's easier to go through.

Q. BY MR. SNELL: Okay. Also attached to your Rule 26 rebuttal report that's been marked as Exhibit 2 is your curriculum vitae; correct?

A. Correct.

Q. This notes it was revised January 2014; correct?

A. Correct. But I have an updated version for you here today.

Q. So we'll mark as Exhibit 3 --

A. I revised it yesterday also.

Q. Okay. So just for the record, can I ask you to line that out just whenever you revised it so there's no confusion for the record. I'm going to mark it separately, but just put the accurate date

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down there for your revision?
A. Revised July 2014.
Q. Okay. So we're marking as Exhibit 3 your revised curriculum vitae, revised as of July 2014; correct?
A. Correct.
Q. And is this your current CV, meaning it's up to date on all your publications, your submissions, things of that nature?
A. Correct.
Q. Do you have an extra copy of your updated CV for you to look at?
A. I have it -- no. I don't. That's my only copy.
MR. KUNTZ: I can get you another copy.
Q. BY MR. SNELL: Is Exhibit 3, your July 2014 curriculum vitae, accurate?
A. To the best of my knowledge, yes.
Q. As I understand it, you did a residency in obstetrics and gynecology?
A. Yes.
Q. And where was that at?
A. At the Mayo Clinic.
Q. You then did an advanced laparoscopy and pelvic pain fellowship at the University of North

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Carolina?
A. Yes.
Q. When you did your obstetrics and gynecology residency, did you do any prolapse or incontinence surgery?
A. I did.
Q. Which ones?
A. We did traditional anterior and posterior repairs, as well as transvaginal retropubic slings and transobturator slings. We also performed the Burch procedure.
Q. Who was it that taught you how to perform the Burch procedure?
A. Dr. Stanhope. Stanhope, S-t-a-n-h-o-p-e.
Q. Who taught you how to do the transvaginal retropubic slings?
A. There was Dr. Klingele, Gebhart and Trabuco.
Q. Did those same physicians teach you how to perform the transvaginal transobturator sling?
A. Dr. Trabuco did that for a period of time, to my recollection. I think he was the only one who tried it.
Q. Were those transvaginal retropubic

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slings polypropylene slings?
A. They were.
Q. Were they the original TVT retropubic slings?
A. They were the Align product, I believe.
Q. Do you know who made the Align product?
A. I believe it's Boston Scientific.
Q. Did you actually pass the instruments during those procedures?
A. I did.
Q. On how many occasions did you do the transvaginal retropubic slings?
A. During my residency?
Q. Um-hum.
A. 25 to 30.
Q. Have you continue to do slings?
A. I have not.
Q. Would it be correct that you have done 25 to 30 transvaginal retropubic slings in your career?
A. Yes.
Q. How many transvaginal transobturator slings have you done in your career?
A. Only a handful. I mean, less than 5. Probably 5.

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Q. Were any of those transvaginal transobturator slings the TVT-O?
A. No.
Q. Do you know which brand they were?
A. They were the Monarch.
Q. So the transvaginal transobturator slings that you would have learned under Trabuco would have been the Monarch sling?
A. Yes.
Q. And that's an outside end sling?
A. Correct.
Q. When you started doing the Align transvaginal retropubic sling, did you investigate whether there were any randomized control trials for that product?
A. As part of our residency, we were aware of some of the randomized control trials for the TVT.
Q. My question is specific to the Align. So you used the Align transvaginal retropubic sling?
A. Yes. Um-hum.
Q. And did you research and determine whether there were randomized control trials on that particular sling at the time you began using it?

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A. I read many RCTs on the transvaginal sling. So I'm sure that some of them had the Align product.
Q. Okay.
A. This was during our urogynecology rotation. And so that was a part of our education.
Q. How long was your urogynecology rotation?
A. I spent a total of six months with urogynecologists.
Q. Had you done other rotations before that during your residency?
A. Our GYN surgery rotations were divided between GYN oncology --
Q. Oncology?
A. Uh-huh. Oncology. And urogynecology and then three months minimally invasive surgery.
Q. When you say three months minimally invasive surgery, what types of surgeries are you talking about?
A. That's going to be the laparoscopic procedures, such as excision of endometriosis, ovarian cystectomies, bilateral salphingo-ophorectomies, lysis of adhesions.
Q. Did you do robotic surgery during your

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GYN training?
A. I did.
Q. What types?
A. In residency we received training of the daVinci robot during both of our urogynecology and oncology rotations. You performed hysterectomies, myomectomies, sacrocolpopexy. And then I went on to do the two-year fellowship in minimally invasive surgery, where I learned laparoscopic hysterectomies, laparoscopic myomectomies, advanced endometriosis surgery, and continued robotic training.
Q. Some of your publications were from the time of your fellowship; is that correct?
A. Correct.
Q. And what was your involvement in those publications?
A. As far as?
Q. What was your role? Were you a part of the original research team?
A. It depends on the publication. So some of them I was the coinvestigator. Anyone who's listed as an author has made a substantial contribution to at least the body of the paper.
Q. How long will it typically take you and

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your team to draft these manuscripts for your papers?
A. I mean, again, it depends on what the project consists of. If you're starting from, I think, a questionnaire and you have to actually send a questionnaire out and wait for it to be returned, I mean, that could take 6 to 12 months. But if you -- if it's more of an opinion paper, 3 to 6 weeks. It depends on the -- the type of research paper that you're writing.
Q. So depending upon the type of research paper you're writing, it would take between 3 weeks and even up to 12 months?
A. And sometimes longer, depending on the group you're working with, if you're waiting for someone to get a draft back to you. I mean, a lot of that is just waiting for people to respond. I think the one paper might actually be missing from my CV.
Yeah, the most recent publication actually is not on here.
Q. And what would that be?
A. That is the post-hysterectomy dyspareunia paper, with my colleagues from North Carolina.

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Q. Is that a -- has it been published?
A. It has, yeah. Yes. This spring.
Q. What journal?
A. Journal of Minimally Invasive Gynecology. It was an invited topic for us to discuss.
Q. Okay. How long did it take you -- what type of paper was that? Was it like -- sounds like a review.
A. A review.
Q. How long did it take you to draft and finalize and submit that review?
A. I would be guessing.
Q. Well, give me your best estimate.
A. You mean between the group of us?
Q. Yes.
A. Probably coordinating 6 to 7 authors, probably 8 to 12 weeks to get a final draft.
Q. And you didn't have to do any original research, such as going and looking at patient charts for this paper, I take it?
A. Correct. Correct.
Q. So even a review article, it doesn't have to go back and look at original charts and things of that nature, it can take up to 8 weeks or

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more for finalization to submit?
A. Between a group of busy clinicians with limited research time, absolutely. Very common.
Q. And are all of the authors on this post-hysterectomy dyspareunia paper people who made substantial contributions to the paper, as you earlier testified to?
A. They're all part of my research team.
Q. Who came up with the idea to do the post-hysterectomy dyspareunia paper?
A. I believe it was an invited topic from the Journal of Minimally Invasive Gynecology.
Q. Was Dr. Steege an author on that paper?
A. I believe he was the senior author on the paper.
Q. What was his role in that paper?
A. He coordinated the topics between the fellows and graduates. He had the final review of the paper in submission. And he also worked on the introduction. And I don't know the specific components of the topics that he provided.
Q. Other than the post-hysterectomy dyspareunia paper published in the Journal of Minimally Invasive Gynecology this year --
A. Um-hum.

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Q. -- other than that, everything else on the CV is up to date?
A. It should be, yes.
Q. You testified earlier you've done anterior and posterior repairs for prolapse. I take it those would be colporrhaphy?
A. Correct.
Q. You've also done sacrocolpopexy?
A. Correct.
Q. Have you done any other procedures for prolapse?
A. No. I do perform what are called colpoplasty at the time of a laparoscopic hysterectomy or vaginal hysterectomy.
Q. When did you first learn to do the sacrocolpopexy?
A. It was part of our curriculum in residency.
Q. Do you remember who taught you to do the sacrocolpopexy?
A. The urogynecologists' names I provided earlier.
Q. Klingele, Gebhart and Dr. Trabuco.
A. Right.
Q. How many sacrocolpopexies have you

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performed in your career?
A. I have participated in -- I estimate 20. I do not perform them now.
Q. Okay. And what type of material did those sacrocolpopexies use to support the vaginal vault?
A. Mesh.
Q. Polypropylene mesh?
A. Polypropylene mesh.
Q. Do you know which brand?
A. I do not.
Q. Do you know the pore size of that mesh?
A. I do not.
Q. Was it monofilament or multifilament polypropylene mesh?
A. I believe it was monofilament.
Q. When you were doing the transvaginal slings, did you know what the pore size to those meshes was?
A. I do not.
Q. Were they monofilament polypropylene meshes to your recollection?
A. They were.
Q. You testified about the surgeries you performed in your fellowship, the laparoscopic

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hysterectomy, myomectomy, advanced endometriosis surgery.
A. Um-hum.
Q. And you continue your robotic training as well; is that correct?
A. Correct.
Q. Is that a full list of the surgeries you performed during your fellowship?
A. No, it is not.
Q. Can you give me the rest of them, please?
A. In addition, in both residency and fellowship, we performed mesh excision.
Q. Okay. Any others?
A. We performed appendectomies, ureterolysis, enterolysis, cystoscopies with hydrodistention. I also performed neuromodulation procedures, including the use of the InterStim device.
In my additional training with pain and anesthesia, I also learned nerve block technique with both ultrasound guidance, fluoroscopic guidance, and nerve stimulator guidance.
Q. Is that different than nerve blocks, nerve stimulator guidance?

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A. You can do nerve blocks blind, but you can also use them with the nerve stimulator or via the other image-guided techniques. It depends on the nerve.

Q. Okay. When you say you can do nerve blocks blind, what do you mean by that?

A. Use anatomic landmarks. There's some nerves that have very little anatomical variance between patients. And people with normal anatomy you're able to perform injections without image-guided devices.

Q. Which nerves are there very little anatomic differentiation between patients?

A. I mean, it depends. I mean, there's -- the other thing is that, when you do perform a nerve block, you are also injecting a large volume of anesthetic that will have a wide area of distribution. So even if you're not in the exact location of the nerve, you will likely be able to provide an appropriate block, if you are within several centimeters. So it depends on the nerve.

Q. Well, I think my question was: You mentioned it's done where nerves -- it's done on nerves with very little anatomic variation between patients.

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So my question is: Which nerves have very little anatomic differentiation between patients?

MR. KUNTZ: Objection.

You can answer.

A. The nerves that we routinely will block with anatomic guidance include nerves of the abdominal wall. And this is the iliohypogastric and ilioinguinal nerve. And while there is anatomic variance, if you use the anterior, superior iliac spine and you are able to feel the muscle layers that you go through, you're able to effectively block that nerve.

Q. BY MR. SNELL: Besides the abdominal wall, are there any other nerves that are blocked in a blind fashion?

A. I mean most nerves have some kind of ability to be blocked in a blind fashion. Do I do all of those? Not necessarily. In my practice, I do the anterior abdominal wall. Occasionally I do the terminal branches of the pudendal nerve as a diagnostic technique in my practice. Occasionally I will block the genitofemoral terminal branch as a diagnostic technique blindly in my practice.

Q. How many mesh excision surgeries have

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you done in your career?

A. I would estimate 20 to 30.

Q. Do you have any idea as to the breakdown of those excision surgeries, whether a certain percent or number were from prolapse mesh like sacrocolpopexy or transvaginal mesh as compared to slings?

A. I notice in my -- in my residency, we removed several of the large prolapse kits, device kits, but in my fellowship we predominantly saw -- we saw a combination of both the kits and the slings. I have never removed mess from a sacrocolpopexy.

Q. Have you read literature that discusses the mesh sometimes has to be removed from sacrocolpopexy?

A. It sometimes does, but that is a much less frequent occurrence. Also in my fellowship we had a mesh pain clinic. So we saw a higher volume of women who had mesh complications. But we did not necessarily always remove the mesh.

Q. And you all weren't the ones putting in the mesh in the first place?

A. Correct. Not in fellowship.

Q. So you didn't have any way of

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scientifically tracking the number of meshes put in to compare that to the number of women who presented to your clinic?

A. That's one of the big issues with this entire, I mean, complaint is that these women are not going back to the primary providers. Also we were taking care of our urogynecologists complications within our own North Carolina practice. But at least what we have seen is that most women -- we had the ability to have a tertiary referral center and a high volume but were not going back to their primary providers who placed the mesh.

Q. The urogynecologists there at the University of North Carolina, do you know what type of slings they used?

A. I don't recall.

Q. So you don't know whether they would have used a TVT retropubic or an Align or some other retropubic sling?

A. I could find out, but I don't recall.

Q. What about transobturator slings for the urogynecologist at UNC? Any idea what type of slings they used?

A. I don't know.

Q. Some of the mesh revision procedures --

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strike that.
When you testified you had done 20 to 30 mesh excision procedures --
A. Yes.
Q. -- is that the total number in your career?
A. That's an estimate.
Q. Okay.
A. But I've seen hundreds of women who have had mesh complications, including sexual pain, erosion and chronic pelvic pain from mesh. That did not mean I necessarily removed it.
Q. Am I correct that of the 20 to 30 mesh excision procedures you've been involved in in your career, you can't say what number of them, if any, were TVT retropubic slings?
And just so we're clear, when I say TVT retropubic, I mean my client's TVT retropubic slings.
A. Oh, then I don't believe they -- I don't believe they have that product at Mayo.
Q. And when you estimated you've removed -- strike that.
When you estimated you've done revision surgeries on 20 to 30 --

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A. Um-hum.
Q. -- meshes, am I correct that you can't testify that any of those were my client's, Ethicon's, TVT retropubic transobturator sling; is that correct?
A. I'm sure I could go back in the medical record and find that information. We saw a variety of patients who have multiple different products of mesh. Do I know any of them was specifically the Ethicon product, I do not know.
Q. So as you sit here today, you cannot testify under oath that you've removed a TVT retropubic transobturator sling made by Ethicon?
A. I've taken care of patients who have had complications from --
Q. Move to strike. This is -- I want to move this deposition along, and I'm asking very simple, straightforward questions. This is a yes or no answer. All right.
As you sit here today, under oath, can you testify that you have removed an Ethicon TVT-O transobturator sling?
A. Not to my knowledge.
Q. Okay. After you finished your fellowship, did you move back here to -- well,

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strike that.
After your fellowship, where did you move then?
A. Well, I stayed an additional -- after I finished my laparoscopic surgery and pelvic pain fellowship, I stayed an additional year at North Carolina.
I was a GYN faculty, as well as pain anesthesia fellow, and worked closely with their team for GYN pain conditions. Once I completed my training there, I moved to Kansas City.
Q. What's your current practice?
A. I'm at the University of Kansas Medical Center, Center for Pelvic Pain and Sexual Health.
Q. And when was it you moved to Kansas City?
A. In July of 2013.
Q. Since finishing your fellowship, have you done any surgeries?
A. I have.
Q. Which ones do you perform, following your -- strike that.
So I'm only interested in now after your fellowship.
A. Okay.

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Q. For the types of surgeries you do at your practice when you were at UNC for that year, but also since you're here.
A. I do the same surgeries.
Q. Can you just give me the quick list?
A. Sure.
Q. Of the ones that you do.
A. I perform laparoscopic hysterectomy, myomectomy, excision of endometriosis, excision of large pelvic masses, lysis of adhesions, appendectomies. I perform robotic myomectomies and hysterectomies. I -- what I did not mention previously, I also perform vulvar surgery. So I do some vestibulectomies. It's excision of the vulvar vestibule for pain. I also perform cystoscopy, cystoscopy with hydrodistention, neuromodulation procedures, and then a variety of blocks.
Q. Okay. The vulvar surgery you perform --
A. Um-hum.
Q. -- what's the reason behind why that -- I assume that that's a painful condition to the woman?
A. It is.
Q. Is that the reason why you perform the surgery?

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A. In some women who have what's called -- the new term is provoked vestibulodynia. It used to be known as vulval vestibulitis. So pain with touching of the vulvar vestibule only.

In the failed medical management, it is reasonable to offer an excision of the vestibule with vaginal advancement.

Q. Do you do any cosmetic vaginal surgeries?

A. I do not. I have performed labioplasty for labial hypertrophy. But I do not perform any for cosmetic purposes or for -- or any of the vaginal rejuvenation procedures.

I also do chemodenervation of the levator ani muscles. That's botulism toxin A. Of some muscles of the pelvic floor for persistent spasm and hypertonicity.

Q. That's called Botox?

A. Botox, yeah. I also do some hysteroscopy, but not a lot of operative hysteroscopy. I do diagnostic hysteroscopy.

Q. Explain what that is.

A. Where you look inside the uterus. You do a dilation and curettage. And it's part of my general gynecology practice. It's bread and butter

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gynecology.

Q. What is the -- strike that.

Is laparoscopy the surgery that one can do to diagnose endometriosis? Or is there some other type of surgery? I might be butchering the words.

A. No. The only way to diagnose endometriosis is a pathologic or histologic evaluation of tissue sampled at the time of laparoscopy or open procedure.

Q. When you say the only way to diagnose endometriosis is a pathologic or histologic evaluation of tissue sampled at the time of laparoscopy or open procedure, what do you mean by a laparoscopy?

A. Like what is a laparoscopy?

Q. Yeah.

A. Or laparoscopic surgery?

Q. Okay.

A. It is where you insufflate the abdomen with carbon dioxide, and you place either one or multiple instruments called trocars into the abdomen, including a site for a camera, and then evaluate the pelvic peritoneum and biopsy any tissue that appears consistent with endometriosis.

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Q. So laparoscopy is basically laparoscopic surgery?

A. Yes.

Q. I'm confused. I didn't know if it was some type of special laparoscopic surgery.

A. No. Just --

Q. Myomectomy? What's that?

A. Removal of uterine fibroids.

Q. Okay. When you say advanced endometriosis surgery --

A. Um-hum.

Q. -- what type of surgery are you talking about there?

A. Endometriosis is -- has many different presentations. And I mean that in a way that it is from a -- it's four different stages of disease. So at the most -- I mean, at stage 4 disease would be where you have retroperitoneal fibrosis of the tissue, displacement of the ureters, adherence of the uterus to the ovaries and bowel and bladder.

Q. So would you do advanced endometriosis surgery only on a stage 4 endometriosis patient?

A. I guess I don't know what you're saying. I mean, that would be considered an advanced procedure. I perform excision of endometriosis on

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all stages.

Q. Okay.

A. However, only certain providers have the clinical skills to do advanced disease.

Q. Why do you perform excision of endometriosis in all stages?

A. It can be for a variety of reasons.

Q. What are those reasons?

A. Fertility is one of them. You can have a pelvic mass, called an endometrioma, which is an endometriosis of an ovary which can become quite large and uncomfortable. You can have small -- you can have peritoneal implants that you can excise.

Q. Peritoneal implants?

A. Implants. Disease on the peritoneum or uterus.

Q. Not some type of implant put into the body?

A. No, no. Sorry. The disease itself on the peritoneum, the bowel, the bladder, the appendix.

Q. Is pelvic pain a reason why you would do endometriosis surgery?

A. Yes. I think by that, I would mean chronic pelvic pain of a reproductive aged woman who

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had significantly painful menses, I would offer her a laparoscopy. If she failed medical management.

Q. When you do endometriosis surgery, do you do it laparoscopically?

A. I do, yes.

Q. The neuromodulation procedures you performed, you identified InterStim.

A. Yes.

Q. Any others?

A. No.

Q. What do you use InterStim for?

A. InterStim is basically neuromodulation of the S3 nerve, and it's indicated for use of urinary symptoms, such as urinary frequency, urgency, incomplete emptying, urinary retention.

Q. How many InterStims have you placed?

A. Approximately -- I've trialed about 15, and permanent placement, about 10.

Q. What's the failure rate of the InterStim?

A. Would you clarify -- as far as the -- because there's two -- it depends on what -- depends on a couple of things. Depends on what you are -- what you're considering failure. It also depends on if you're talking about the trial or permanent

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placement.

So one of the beauties of the device is that you send someone home with a seven to ten-day trial. I have my patients mark their urinary symptoms as well as any pain symptoms that they have.

And then I would say a trial that would be considered positive enough to proceed with a permanent implant would be greater than 50 percent of those symptoms, improvement of greater than 50 percent of their symptoms.

Q. Okay. So the woman has symptoms of urge incontinence, you do a seven to ten-day trial with the InterStim. And you would consider it successful such that you would offer permanent placement if the woman has greater than 50 percent symptom resolution of her urgency?

A. Only if they failed or could not tolerate the medications or lifestyle modifications for urgency incontinence and that she felt it was beneficial to proceed with the device, we would consider it.

Q. If there was a greater than 50 percent symptom resolution?

A. Correct.

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Q. And the medications and lifestyle are the first line therapy?

A. They are.

Q. When you were describing how a laparoscopy is done, you said that the abdomen is insufflated with the carbon dioxide; correct?

A. Correct.

Q. What do you mean by the abandon is insufflated?

A. You make a small incision usually in the umbilicus and insert a device called a varus needle, which is a closed technique. And you basically place a needle into the abandon. And then once you're past the peritoneum, you connect a tube of gas that's CO2, verify low opening pressures to make sure that you're actually in the cavity and not in a small space, and then fill the abdomen with air to approximately 15 milliliters of mercury of pressure. And then you place your instrument, your trocar.

Q. Where did you learn to perform insufflation?

A. In residency.

Q. Is the varus needle the only needle or instrument used to insufflate?

A. It's the one I use most often, but there

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are multiple different techniques. One of them is a blind technique, where you make an incision and blindly place a port. You can also do something called the open technique or Hasson technique, H-a-s-s-o-n, I believe, and it's where you make a larger incision through the umbilicus and visualize going through the layers and placing the port under direct visualization.

Q. When you say you blindly place a port, what are you meaning by that?

A. You would just -- you're just not looking through the layers as you place it. So some people will do that. I don't do that. You can also do the Optivue technique, where instead of blindly placing the port, you are not visualizing going through the layers of the abdominal wall, and you can insert the 5-millimeter camera through a port. That's never been shown to decrease complications, but some feel more comfortable placing the device that way.

Q. When you say some surgeons blindly place the port, are you talking about a trocar?

A. Some will; correct.

Q. So when you said port, that's --

A. Trocar.

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Q. That's the equivalent of a trocar?
A. Yes. Yes.
Q. Is the insertion of the varus needle into the abdomen a blind procedure as well?
A. Yes.
Q. Are there risks with that?
A. Very few.
Q. What are they?
A. There are risks of damaging the bowel, large vessels in the abdomen, the bladder, potentially. But the patients that we use the varus needle on, you decrease their risk by not performing it in people who have had previous abdominal procedures. You can also place it in a left upper quadrant, if you are trying to avoid a prior midline incision. So there are various ways to use the varus needles, but the varus needle is a very safe device.
Q. You've probably read the literature which reports various rates of injury to patients receiving blind varus needle entry during the time of laparoscopy?
A. Am I familiar with it?
Q. Um-hum.
A. I am.

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Q. And you believe that the risks are, did you say, very few or low?
A. Yes. They're significantly less than 1 percent.
Q. Okay. I take it, when you were doing the transvaginal slings during your residency, you were involved in counseling of those patients about the risks of the surgery?
A. I was.
Q. Were you involved in counseling patients about the risks of other incontinence surgeries like the Burch as well?
A. I was.
Q. Were you involved in counseling patients about the risks of prolapse repairs?
A. Yes.
Q. When did you first learn that pain was a potential complication with surgery?
A. Whenever?
Q. Yes.
A. I mean, it's medical school.
Q. When did you first learn that pain was a potential complication with a vaginal surgery?
A. Can you clarify? Are you talking about acute pain immediately after surgery or subacute

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pain or chronic, post-surgical pain. I don't -- I mean, because everyone -- I mean, almost everyone that has surgery has some pain associated with it.
Q. How do you define chronic pain?
A. What kind of chronic pain?
Q. I'm asking you.
A. Like chronic pelvic pain would be -- that would be the thing I'm most familiar with. So chronic pelvic pain would be continuous or intermittent time period the same pain for greater than six months.
Q. Is that statement that the chronic pain -- strike that.
Is the statement you just made that chronic pelvic pain is pain that persists for more than six months a statement that comes out of one of the professional organization guidelines, like the Ob/Gyn or urology?
A. ACOG?
Q. Yes.
A. And most of them do say six months. Some organizations will say as little as three months, but most, to my knowledge, are six months.
Q. Your standard for chronic pelvic pain, though, is six months for consistent pain?

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A. Of the same pain; correct. And that's what I would use from a research standpoint as well.
Q. So when did you first learn that chronic pain was a risk of surgery?
A. I think you're introduced to some of that in medical school. It's not common after most surgeries. So I would probably say the -- my -- most of my education was in -- began in residency. And then I learned a significantly larger amount in fellowship at my additional training.
Q. When did you first learn that dyspareunia was a potential risk with the vaginal surgery?
A. Which type of vaginal surgery?
Q. Any type of vaginal surgery.
A. I think you have to kind of specify because there are certain procedures that we avoid now due to the risk of dyspareunia. And it depends on what type of dyspareunia, insertional, deep dyspareunia. Is it painful at the beginning of intercourse, but then it dissipates once she's well lubricated. Is it -- you know, there's multiple different types. Is it provoked vestibulodynia. Is it scarring from a posterior repair. Is it pelvic floor tension. Is it structural, such as bladder,

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the bowel, the cervix, the uterus. I mean, I would need you to specify.
Q. How about this: Are there any vaginal surgeries that you do that do not have the potential risk of dyspareunia?
A. Dyspareunia as in?
Q. Pain with intercourse.
A. At the opening of the vagina? At the --
Q. Any time.
A. In like how long -- I mean, immediately after? 6 months? 12 months? I --
Q. My question is broader. My question is simply: Are there any vaginal surgeries you do that do not have a potential risk of dyspareunia?
A. I don't think I can answer that.
MR. KUNTZ: Objection. Objection.
Q. BY MR. SNELL: You can answer.
A. I can't answer. I mean, I think it's just too broad. I would really need you to specify like a vestibulitis or provoked vestibulodynia. Is it painful just -- I mean, I would need a more specific question.
Q. If you're doing a hysterectomy --
A. Okay.
Q. -- is there a potential risk of

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dyspareunia after that?
A. Insertional dyspareunia, probably incredibly low.
Mid or deep dyspareunia, there's a low risk.
Q. Do you counsel your patients on that?
A. I do.
Q. That's what I'm getting at, you know, what type of vaginal surgeries do you do where there's a risk of dyspareunia?
A. I know I don't place mesh. I think that risk is great.
MR. SNELL: Move to strike as nonresponsive.
Q. BY MR. SNELL: What type of surgeries do you do that have a risk of dyspareunia that you counsel your patients on?
A. For example, the vestibulectomy.
Q. Okay.
A. Which is a procedure we do to remove the vestibule which is causing pain.
Q. Um-hum.
A. One of the potential risks would be scarring of the posterior vagina.
However, we probably would get these

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women into physical therapy after surgery to improve their outcomes.
Q. What's the -- what's the physical therapy regimen? Is it to break up the scar tissue?
A. To mobilize the tissue, yes. And also a huge part of physical therapy is the cognitive behavior therapy component. So you have a woman who has not been able to have pain-free intercourse for either her entire life or a period of months to years. And one of the most important parts of physical therapy is having her more -- become more comfortable with inserting things into the vagina, feeling more comfortable with her own body. I think that is another component of it as well. It also treats any musculoskeletal pain that they may have from either surgery or prior to surgery from the pain process itself.
MR. KUNTZ: Burt, whenever you get to a stopping point, let me know.
MR. SNELL: We can stop now.
MR. KUNTZ: I just want to take a quick break.
(Recessed from 10:08 a.m. to 10:17 a.m.)
Q. BY MR. SNELL: The web site identifies

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you as treating chronic pain disorder and pelvic pain; is that correct?
A. Is that my web site?
Q. I believe so. Clinical practice focused on pain management, pelvic pain.
A. That would be correct.
Q. And some of the pain management and pelvic pain that you deal with is chronic pelvic pain or chronic pain?
A. Almost all of my pain is chronic.
Q. And what are the conditions that lead to that chronic pain that you treat?
A. Where would you like me to begin? Chronic pelvic pain?
Q. Sure.
A. It's a very broad topic. I probably would just break it down by organ systems. I mean, so it could be the reproductive system.
Q. Okay.
A. Well, if you look at -- so reproductive system would include -- I mean, anything structural with the reproductive organs themselves. So the uterus: Necrotic fibroids, severe cramping with menses called dysmenorrhea, distention of the fallopian tunes, such as hydrosalpinges or

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pyosalpinges, from an inflammatory disease of the pelvis, such as like pelvic inflammatory disease, a chlamydia infection. You can have chronic pain from those conditions. You can have chronic pain from endometriosis.

Q. Is that structural?

A. It -- I mean, it has implants. So it is a -- you would -- implants are large masses on the ovaries or nodules of the uterosacral ligament. So it is -- I mean, it's structural.

Then you could have the GI tract. So you could have inflammatory bowel disease, irritable bowel syndrome can be associated with some pain. Diverticulitis can be an ebb and flow of chronicity and cause some pain.

Chronic appendicitis. The GU syndrome or -- so you have interstitial cystitis. Painful bladder syndrome. Chronic ureteritis, chronic urinary tract infections, a foreign body in the bladder can cause chronic pain, like a stone -- residual stone or -- like from a renal stone, a suture. Like those can actually cause chronic discomfort in contractability of the bladder.

You can have the pelvic floor muscles. Those are normally in response to something, but

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they can definitely contribute to chronic pain of the pelvis. So that would be the levator ani complex and the obturator muscle, the piriformis muscles. You can have a neuropathic condition of the lower abdominal wall or the pelvis. So that would be -- you could have an ilioinguinal or iliohypogastric neuropathy, genitofemoral neuropathy, obturator neuropathy, pudendal neuropathy. All of those can cause chronic pelvic pain.

You can have something like -- the musculoskeletal system, like the hip, is in close proximity to the pelvis.

Q. The hip?

A. The hip. So I've had patients who have had a labrale tear, but they describe it as groin and pelvic pain and end up in my clinic, but it's usually orthopedic in nature. I would say those are the most common that I see, just off the top of my head.

Q. Okay.

A. And then you have, you know, vulvar pain syndrome. So generalized vulvodynia, provoked vestibulodynia.

Q. Is all of your current practice at the

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University of Kansas or do you split time between the University of Kansas And University of North Carolina?

A. Now all my practice is at the University of Kansas.

Q. Do you -- when you do your surgeries, do you use -- I take it you use sutures during your surgeries; correct?

A. I do.

Q. Do you use any polypropylene sutures?

A. Not in the surgeries I perform now.

Q. Did you ever use any polypropylene sutures for any of your surgeries?

A. I'm sure during residency I have.

Q. Do you use any permanent sutures in your surgeries?

A. I currently don't. I will use some -- I'll use some silk to oversew the bowel, if there's a bowel injury. But actually -- yeah. I'm trying to think. I don't think I do now. I'm just trying to go through all my procedures. I use a -- no. Never mind. No. I use -- I was just trying to think of all my things.

I occasionally will use a Hem-o-Lok clip on an appendix -- of appendix, but that's the only

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thing that is non-absorbable.

Q. So a little while ago we discussed the different conditions that could lead to chronic pelvic pain.

Can you tell me the different conditions that can lead to -- strike that.

Do you consider chronic dyspareunia to be within the realm of chronic pelvic pain?

A. I do. Yeah.

Q. The conditions that can lead to chronic dyspareunia, are those the same as those you enumerated with respect to chronic pelvic pain? The structural endometriosis, GI tract, GU, pelvic floor muscles, neuropathic, musculoskeletal and vulvar pain syndromes?

A. I think the one thing I also excluded, and it's blatantly obvious, is the mesh conditions as well. So foreign body in the vagina. And I would say that some of those could contribute to dyspareunia, but it depends on the type of dyspareunia. And that's really important in my clinical practice, because it allows me to have a true diagnosis and then actually treat my patients.

Q. When a patient comes in and she's complaining of pain, walk me through the process of

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how you would assess her? Starting with, you know, she's a new patient of yours.
A. Sure.
Q. Let me just clean the question up.
A. Okay.
Q. So walk me through the process by which you evaluate a new patient.
A. Okay. A new any patient?
Q. A new patient with pain.
A. Patient with pain.
So my practice is a -- is a pelvic pain and sexual health practice. The majority of my patients who have been referred are referred from either clinicians within my department to my division or within the University of Kansas or outside. So it's a referral-based practice.
Q. Okay.
A. With a large catchment area.
Most patients who have presented to me have a diagnosis of chronic pain, and have tried multiple treatments and therapies prior to a referral to myself. So that just is a normal patient I see.
So the -- when the patient arrives, she may or may not have outside medical records. If she

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does not, I would send a request for those. I think an important part of what I do is to make sure we don't duplicate treatments that have been performed and not worked, as well as medications.
And then I have approximately 60 minutes with the patient, for my new patients. We do a detailed history, which I think is incredibly important in deciphering the etiology of her pain, aggravating and alleviating factors, but potential trigger for her initial pain process, and then subsequent responses from the remainder of her symptoms.
I then -- after a detailed history -- I'm not going to go into that with you, but it's very similar to what I have given you for Ms. Huskey -- perform a thorough physical examination. And that includes an examination of the patient's back. So musculoskeletal system, her abdomen, and the pelvic exam. You have a visual inspection of the external genitalia.
Do you want me to go into the pelvic exam?
Q. Yes.
A. So -- I mean, you would definitively be led by what some of her complaints are, but

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traditionally I would -- detailed examination of the vulva, including the labia majora, labia minora, the clitoris, the clitoral hood, the urethra, the vulvar vestibule, the hymenal ring, the anus. This is all an inspection.
I want to make sure that the tissue appears normal. I want to identify if there's any tenderness or erythema of the tissue. I'll use a Q-Tip -- I'll perform a Q-Tip exam, where I'll evaluate the vulvar vestibule. If she has no other complaints of the vulva, I don't perform a neurosensory exam of the vulva. That's more detailed.
I'll then lightly lubricate the Q-Tip, and I'll insert it into the vagina and assess her response. Is that neutral or unpleasant. I will then use a single digit. I'll have her perform a contraction of her pelvic floor muscles to assess her Kegel strength.
I then will perform the pelvic floor muscle exam, applying approximately 2 kilograms of pressures to the levator ani muscles, the obturator internus, and the piriformis muscles bilaterally. When I evaluate the obturator internus muscle, I will have her abduct her thigh in order to fully

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palpate the muscle.
And then I will ask her, as I evaluate each of these muscles, if she has a pain or pressure response. I'm also able to assess tonicity of the muscles. So if they're -- if they're normal or if they are hypertonic or contracting.
And then I will evaluate the urethra, to see if she has any tenderness in the urethra itself, the bladder neck and the base of the bladder. I'll use a single digit to see if she has any discomfort behind the pubic arch.
And then we'll perform a two-digit exam to manipulate the cervix, to see if she has cervical tenderness. I will then evaluate the mobility and size of the uterus, see if she has any tenderness of the uterus. I will then apply my abdominal hand to evaluate the size of the uterus, evaluate the adnexa, see if there's any tenderness or fullness in the adnexa.
I'll perform a rectovaginal exam. The patients that have complaints of -- defecatory complaints, evaluate the rectovaginal septum, and then change gloves and perform a speculum exam.
So we'll look at the vagina, looking for -- I already would do an initial assessment of

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the introitus at the beginning looking for genital atrophy. I insert the speculum. I'm looking for any lesions, abnormal discharge, erythema of the cervix, any structural changes of the vagina itself. I also assess the vaginal walls with a Q-Tip to see if she has any tenderness elucidated along the vaginal sidewalls and the vaginal apex.

If she's had a hysterectomy, I'll also palpate the vaginal cuff to see if she has any tenderness of the cuff itself during the speculum exam.

One thing that's very important is that during the exam, if the woman has reported pain with intercourse, I use the examination and her history to provide a more thorough picture of where her dyspareunia would be. So if she says she has insertional pain, I take time to really focus on the opening of the vagina, the levators, the structure of the vagina, the urethra. And then I ask her, is this the pain that you feel with intercourse. So I try to reproduce the pain. It helps me create my plan and decide what our next steps are.

And in my patients who have had a mesh procedure before, I look for any erosive disease, general atrophy, scarring around the mesh,

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displacement of the urethra from scarring or any folding or changes in the anatomy of the mesh through the vaginal epithelium.

Q. Do you use questionnaires for your patients?

A. We have a review of symptoms sheet that is mandated by the university that we use. In my new patients, there is a sheet on -- provided for medications and allergies, but I do not use any validated questionnaires at this time.

One of my problems with the questionnaires we do have for sexual function in assessing any type of pain is it's not specific enough. So even if -- first of all, the women are coming to me because they have a pain complaint or sexual dysfunction complaint. And secondly, it's not specific enough to really provide any useful information for me during my clinical visit. Where I think it may be helpful is as my practice continues to expand, it would be looking at -- from a research standpoint at maybe a way to evaluate improvement.

However, these -- the questionnaires we have currently for sexual health and pelvic pain are not specific enough, in my opinion.

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Q. Okay. Do you do pain mapping on your patients?

A. Could you clarify that term?

Q. You don't know what pain mapping is?

A. I mean, do I do an evaluation to identify pain? The way I know pain mapping is a technique that is rarely performed. It is a laparoscopic technique. I do a thorough examination in some patients who have specific vulvar complaints in neurosensory exam.

Q. Have you written on pain mapping, published about it?

A. It's been described by John Steege before. But it's not something we use regularly in our practice.

Q. Why don't you regularly use pain mapping in your practice?

A. It's invasive, and, from my understanding, has not produced the results that they had expected. So there's -- it's patient selection.

And are you -- are you -- are you talking about the laparoscopic pain mapping? I just want to make sure I understand what you're saying, or just pain mapping as doing a thorough physical

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exam and neurosensory exam? I guess I don't know which one you're asking.

Q. You were testifying about laparoscopic pain mapping; correct?

A. Yes. But is that what you were asking?

Q. Yeah. I was asking about the pain mapping that Dr. Steege has written about and that you would have been trained on, I assume.

A. We have done it before. It is designed for an attempt to evaluate visceral pain. So just to kind of clarify, visceral pain is going to be defuse nonspecific pain.

And the idea behind pain mapping is, well, if we put our patients to sleep and we go in and we touch their visceral structures, like the bladder, the bowel, the uterus, the ovary, maybe they can tell us if that's where they feel their pain.

The problem is that's not how visceral innervation works. It works when I -- visceral innervation is very different than somatic innervation. Somatic is if you close your eyes and I touch you on your right index finger, you know exactly where I'm touching you. The idea is trying to apply that to the pelvic viscera, and that's why

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it's really clinically inconclusive. And we don't use it regularly in practice because you can't just close someone's eyes and go in and say, is this your pain, because it's really difficult to do.

Q. Are you board certified in female pelvic medicine and reconstructive surgery?

A. I'm a board certified obstetrician and gynecologist. Not a urogynecologist. That was not my training.

Q. You have not sat for the female pelvic medicine and reconstructive subspecialty boards?

A. That was not my fellowship training, so, no.

Q. Do you have any intention of taking those subspecialty boards, female pelvic medicine and reconstructive surgery?

A. I have no intention of doing a fellowship in urogynecology. I've done enough fellowships.

Q. Your CV lists the professional organizations you are a member of; correct?

A. Correct.

Q. What's the value of being associated with those organizations?

A. As far as the -- I'm an active member in

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all of the organizations I have listed. I believe most -- American College of Obstetricians and Gynecologists actually has one of the highest membership rates of any specialty, which is -- is wonderful to be a part of. They provide a -- I mean, a collegiality. I mean, you go to meetings with these groups. They provide some structure. They don't always represent the ideas of the -- all of the members. So that's something to keep in mind. But they, in general, will provide some recommendations based on opinion that can help guide practitioners. It allows for a forum for debate, intellectual community.

I mean, I think that all of the organizations I'm involved in, at least, provide that for me. I'm also involved in -- heavily involved in the International Pelvic Pain Society, including development of their basics pain course. And I'm looking forward to future leadership positions in both that community as well as Association of American Gynecological Laparoscopists, AAGL.

Q. I forgot to ask you: Earlier you were testifying about your procedure for evaluating a new patient who comes in --

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A. Sure.

Q. -- with pain.

A. Sure.

Q. Do you usually have a second doctor there in the room with you?

A. I usually have a medical student or resident in the room with me, which is a great platform for teaching. Because my specialty is unique, I have a lot of learners, which is really fun for me to teach on a clinical level. So I often do have someone with me.

Q. Am I correct, though, that when you see your patients for pain, you do not normally see them with another doctor who also is experienced in pain management at the same time?

A. Not normally. However, within my center, we have a total of four providers, and we do patient share quite a bit. So especially with our very difficult, complex patients, where there's not a lot of treatment options, we will patient share. So I will see someone and then refer them within a very short time period -- not within the same visit, but in a very short time period to maybe one of my other colleagues who has maybe a different view on a patient or a different clinical interest.

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We also will have a pain board meeting once a month, where we work with not only all of the providers in my practice for the Center for Pelvic Pain and Sexual Health, we work with a sexual therapist, who sees a majority of our patients who have sexual dysfunction that may have resulted from one of their pain conditions. And we also work with two physical therapists who do nothing but pelvic floor health. And so we meet on a regular basis to discuss those difficult patients.

Q. When you evaluated Mrs. Huskey, Dr. Steege was present; correct?

A. We did the exam together. We did the interview separately.

Q. In your normal practice, you do not normally do the exam of a patient with another doctor like Dr. Steege; correct?

A. I wish I could.

Q. Is the answer to my question that's correct?

A. Not in a normal practice, but I would like to clarify that in our mesh pain clinic in fellowship that was run by both a pain doctor like myself and a urogynecologist. So in those mesh pain patients, we had two sets of consultant level eyes

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on those women because they're complicated.
And really what we were trying to decide there is, is it beneficial to remove this mesh. Will the person get better? Should we do something that is less invasive. So in that setting, that was -- that was different, and I wish we had that for all of our patients.
Q. Well, when you say there was two sets of consultant level eyes, you're not saying that the pain doctor and the urogynecologist would both be present at the same time?
A. Correct. They would be.
Q. And that was at UNC?
A. Yes.
Q. Am I correct that in your normal clinic it would not be the case that you and a doctor like Dr. Steege, who is a pain doctor, would both evaluate the patient at the same time?
A. In normal GYN clinic, no.
Q. I'm not correct?
A. I mean, that is correct. But in most of those cases, there's not complex pain syndromes that you're evaluating as well.
Q. Is it correct then that most of your patients do not have complex pain syndromes?

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A. Most of my patients have a chronic pain syndrome. If I had the ability to have someone assist me with my mesh pain patients, I absolutely would. I mean, I'm kind of the end of the road with these patients, and there's not a lot of guidance in the management of their care. So I'm constantly asking questions and querying my urogynecologists, not in the same clinic, but regarding the same patients, absolutely. Asking them, you know, do you think mesh removal in this person would be helpful. Do you think this person might benefit from neuromodulation. Do you think this person might, even though she failed the trial one medication, do well with another. I mean, that's my clinical practice.
Q. At the time you evaluated Mrs. Huskey, you knew she was involved in litigation; correct?
A. I did.
Q. How many times previous to this case have you been an expert in a litigation matter?
A. I've been acting as an independent medical examiner for about 15 to 20 patients. My role is to, as independently as possible, evaluate the patient's medical record, the history they provide me at the visit I see them, the history they

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provide John Steege, our combined physical examination, and try to factor out the etiology of their chronic pain.
In the patients that we've seen, not all of them we -- our conclusions were not that mesh caused their pain in all of them.
Q. You're aware I took Dr. Steege's deposition?
A. Yes.
Q. You read his transcript?
A. I did.
Q. Okay.
A. I don't know if I read it all word for word, but I glanced over it.
Q. You're being paid by the plaintiffs in this case?
A. Most medical experts are paid, yes. I am being paid.
MR. SNELL: Move to strike. Move to strike.
Q. BY MR. SNELL: It's a simple yes or no.
A. Yes.
Q. Let me just ask it plainly. What I want here is to have a record. Simple questions, I would appreciate it if you would say yes or no.

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You're here paid by the plaintiffs today; correct?
A. I am.
Q. And you're an expert for the plaintiff; correct?
A. I'm a medical expert, yes.
Q. And what is -- when do -- strike that.
When were you first retained for this Huskey case?
A. I believe I saw her in January. I don't know the exact date of the exam. She was examined -- we saw her January 11, 2014.
Q. When were you first retained by the plaintiffs to be an expert in the mesh litigation?
A. The first patient I saw was in the spring, I believe, April of 2013.
Q. Which attorney or law firm retained you?
A. Mueller law.
Q. Mark Mueller's law firm?
A. Margaret Thompson. I was approached by Margaret Thompson and John Steege to evaluate these patients because of my additional training with pain anesthesia. But I think that is the law firm.
Q. Okay. So you were initially approached by Margaret Thompson and Dr. Steege to participate

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as an expert in this litigation?
A. Yes.
Q. And were you told what your role would be?
A. As an independent medical examiner.
Q. Was it your understanding that you would be evaluating patients at the same time as Dr. Steege?
A. Yes. And part of that was logistics. I had moved to Kansas City. So they ended up trying to make it in one -- a one-day visit so I could fly into North Carolina and we could evaluate -- have the patient fly only one time and see both of us.
So all of our interviews were independent and the medical exam was performed together.
Q. Did you bring your invoices or billing to the deposition?
A. I have not billed for Ms. Huskey's case.
Q. How much have you billed in the mesh litigation while serving as a plaintiff's expert?
A. I have billed approximately -- I think 80 hours is what I've billed so far.
Q. And who do you usually send those invoices to?

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A. To Mueller law.
MR. KUNTZ: Just note our objection to that request, but you can ask her about it.
MR. SNELL: Well, I'm going to demand -- ask production.
Q. BY MR. SNELL: You didn't bring those invoices with you here today; did you?
MR. KUNTZ: We'll object. We're not producing invoices aside from the Huskey case, and one doesn't exist.
MR. SNELL: Well, I'll ask for it, but I understand your objection.
Q. BY MR. SNELL: You have not billed for the Huskey case?
A. No.
Q. How many hours have you spent on the Huskey case?
A. Including my deposition prep, approximately 50 hours.
Q. So you have spent approximately 50 hours on the Huskey case?
A. Reviewing the literature -- or reviewing the medical records; that's correct.
Q. How were you -- strike that.
When were you first retained to work on

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the Huskey case?
A. The -- are you talking about a financial retainer?
Q. No. I mean --
A. The ones where I was asked to do it?
Q. Yeah. Let me just make it simple.
A. Okay.
Q. When were you first asked to serve as an expert in the Huskey case?
A. To serve as an expert. I was asked to write a rebuttal to Dr. Pradmudji's opinions, and that was in April of 2014. So up until that point, I had not planned on testifying as a medical expert, but I was asked to write the rebuttal.
Q. When were you first requested to be involved in Mrs. Huskey's -- maybe we're not communicating. Maybe my question is incorrect.
A. I'm sorry.
Q. That's okay.
So you evaluated Mrs. Huskey back in January of 2014; correct?
A. As I had been doing -- correct, with other cases.
Q. And you don't do those for free; correct?

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A. Correct.
Q. You expect to be paid?
A. Correct.
Q. When you evaluated Mrs. Huskey, you expected to be paid?
A. As a medical examiner, yes.
Q. By the plaintiff's law firm; correct?
A. Correct.
Q. So how did you first come to learn about the Huskey case?
A. I guess I -- I mean, I saw her January of 2011 -- or of 2014. January 11, 2014, was when I did perform her medical exam.
I was asked to address Dr. Pradmudji's opinions and write a rebuttal in April of 2014.
Q. How did you know that you were supposed to go and evaluate Mrs. Huskey on January 11th, 2014?
A. Because I had been asked to be a medical examiner.
Q. Okay. When were you asked to be a medical examiner to see Mrs. Huskey?
A. The date?
Q. Yes.
A. Oh. It was pretty last minute. So I

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don't -- I mean, it was -- my travel plans were not finalized for that trip until, I think, January -- early January. I can't remember the exact date. But --

Q. You didn't know Mrs. Huskey before you saw her; correct?

A. No.

Q. No, I'm not correct?

A. No. I mean correct. You're correct. I did not know her.

Q. Who makes the travel plans when you would do the independent medical examination of -- strike that.

Who makes these travel plans when you go to evaluate Mrs. Huskey?

A. The law firm.

Q. And when did you get to North Carolina for your examination of Mrs. Huskey?

A. January 10th.

Q. So you would come in the day before and the next day do the evaluation?

A. Correct.

Q. What form of communication was used to tell you to evaluate Mrs. Huskey?

A. I think I was invited by email, but I

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didn't receive -- I don't believe I received her medical records until the day before.

Q. When did you receive Mrs. Huskey's medical records?

A. We received them late. We received them on the 10th, I believe.

Q. And what medical records did you receive from Mrs. Huskey on January 10th?

A. I mean, I'm guessing. I did not look at her medical records until after we saw her. So they may have been available to me on the 10th, but I did not look at them until later that week.

Q. Okay.

A. It's not uncommon for evaluating a patient that's been referred that does not come without medical records.

Q. So you did not look at Mrs. Huskey's medical records until after you had evaluated her?

A. Yes.

Q. And after your evaluation of Mrs. Huskey, did you return back to Kansas City on January 11th?

A. I believe I returned on the -- I stayed an additional day. So I returned on the 14th, I believe. I stayed through the weekend.

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Q. Take a look at your deposition notice. It's been marked as Exhibit 1. And I want to direct you to Schedule A, which are documents relating to the fees, billing, and time spent --

A. Um-hum.

Q. -- in connection with your opinions in any pelvic mesh litigation.

Did you bring any of these documents here today?

A. No, I have not completed my billing.

Q. Okay. And for your billing on other pelvic mesh cases, you have billed, but you have not brought those here today; correct?

A. I have not completed my billing on all of them.

MR. KUNTZ: I'll note our objection to that request as well.

Q. BY MR. SNELL: What is your hourly rate?

A. $500 an hour.

Q. Is that for reviews, examinations, testimony?

A. Correct.

Q. You don't have a flat fee for medical examination?

A. I didn't, no.

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Q. I'm sorry?

A. I'm sorry. So when I was in North Carolina, I would just bill the workday.

Q. Okay.

A. For the hourly fee.

Q. You brought your CV.

Have you ever given testimony before?

A. No.

Q. Okay. And your updated CV, now with the addition of the one article we discussed, the post-hysterectomy dyspareunia, that's up to date with regard to your publications; correct?

A. That should be, in addition to whatever else is listed in my CV.

Q. When you evaluated Mrs. Huskey, did you make any notes?

A. I did. On my computer.

Q. Where are those notes?

A. They ended up being a compilation of the draft.

Q. You still have those notes?

A. I have drafts of those on my computer, yes.

Q. Okay.

A. Though I may not have all of them. My

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hard drive on my computer, I don't know, April, broke. But I have some copies, yes.
Q. Did you send any of your notes from your medical examination to Dr. Steege?
A. He documented the medical exam, and then we shared that documentation immediately after each patient.
Q. You say they would share -- strike that.
When you shared the documentation of the medical examination with Dr. Steege, what do you mean by that?
A. We -- immediately after evaluating the patient, we'd complete the physical exam component to make sure we agreed on all areas of the exam.
Q. And you completed this physical examination component where you wanted to make sure that you agreed on all elements of the exam.
A. Yes.
Q. What type of document was that?
A. It was a Word document. That ended up being the basis of this CV report.
Q. And that Word document, do you have a copy of it?
A. I don't. I'm sure he does. It was on his computer.

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Q. The Word document was never shared with you?
A. It was -- might have been emailed to me.
Q. Did you bring that document here today?
A. It ended up being a part of my -- or our initial expert report. So I don't have that with me.
Q. Did you take any notes at the time of your examination of Mrs. Huskey?
A. Just a shared Word document.
Q. But --
A. No handwritten notes.
Q. Okay. The shared Word document is the document that was created in connection with the evaluation of Mrs. Huskey?
A. And it ended up being the basis of the draft for the report. So we didn't have multiple different documents flying around. Mostly for our own organizational purposes, we'd have one chart for Ms. Huskey, one chart for the next patient. It makes it -- especially when you're taking the history of multiple patients with very similar complaints, it makes it very important that you have it well documented, and that we agreed on the exam and made sure the history was complete, hence having

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two separate providers take a history. It made the reports more thorough.
MR. SNELL: Move to strike. I don't believe that was responsive to my question.
Q. BY MR. SNELL: Explain to me how the examination of Mrs. Huskey occurred from the time you arrived in North Carolina on the 10th.
A. So I arrived on the 10th. I went to the hotel. I went to sleep. I arrived very late. And then in the morning we started approximately 8:00 a.m.
We -- I mean, these are my colleagues and mentors. I saw them at 8:00 a.m. And I don't know what order she was, but we began seeing our patients. And so we would each interview a patient and then switch the patients. So I would have an hour, and he would have approximately an hour to interview the patient.
We would then go into the exam room of one patient together. I would perform the musculoskeletal examination of the back, the lower extremities, and then the neurosensory exam of the vulva and vagina, and we both performed the genitourinary exam.
Q. And then after that?

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A. And then we would have the patient dress. We would discuss both the patient's history and physical exam. And then we spoke with the patient about our recommendations, because just as much as they were there to be part of the independent medical exam, we were some of the first pelvic pain experts that several of them had seen. And so we discussed what we believed would be the most efficacious treatment options and interventions for these patients. We talked to them about their relationships with their partners, about the use of physical therapy, sexual therapy. It was -- it was -- and the women were incredibly grateful. So it was, all in all, a wonderful experience.
And then we would complete that single patient and we'd go and examine the next patient. It was a long day.
Q. How many patients did you examine that day?
A. I don't know how many patients that day, but normally between four and seven.
Q. And were all of these patients patients who are involved in litigation?
A. All of them were.
Q. When you saw Mrs. Huskey, am I correct

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that you took a history of her that lasted about an hour?
A. Correct.
Q. Did you take any notes during that history, or did you all just remember this in your head?
A. I took notes.
Q. Did you bring those notes here today?
A. Those were part of the combined draft. So I don't have them with me. I was --
Q. The combined draft of what?
A. Of the Steege expert report. So we both took individual notes. They're basically a ghost of that draft and then he combined them.
Q. So Dr. Steege took your notes and put them into your expert report?
A. They were a compilation of both of our histories; correct.
Q. Do you still have your notes that you took during your hour-long history of Mrs. Huskey?
A. Ones that were not on the hard drive of my computer that was destroyed, I can look for those.
Q. Did you ever email the lawyers or Dr. Steege or anybody else your notes from your

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history?
A. I'm assuming that's how they got to Dr. Steege.
MR. SNELL: I'm going to ask for those notes from the IME that she performed, particularly the history she took from Mrs. Huskey.
THE WITNESS: Sure. That's one of the great things about it is, when we would meet afterwards, we both elicited different bits of information from the patient. And I think with his expertise with sexual therapy, we were really focusing on the relationship components of the patients and their partners and lack of intimacy. And then mine from more of a structural anesthesia component. It made it a very thorough history.
Q. BY MR. SNELL: Did you see Mrs. Huskey after January 11th, 2014?
A. I did not see her. I spoke with her yesterday.
Q. What was your understanding as to your role in the Huskey case before you looked at Dr. Pradmudji's report?
A. That I was an independent medical examiner.
Q. Okay. Have you ever spoken to any of

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Mrs. Huskey's doctors?
A. No.
Q. Okay. Have you ever spoken to any of Mrs. Huskey's family members other than her husband?
A. No.
Q. Have you ever spoken to any of Mrs. Huskey's therapists or other medical professionals?
A. No.
Q. When you spoke with Mrs. Huskey yesterday, how long did that conversation take place?
A. Approximately 30 minutes. And mostly it was about her --
Q. Well, let me -- that was responsive, the 30 minutes.
Why'd you speak to Mrs. Huskey yesterday?
A. I wanted to clarify a couple of her discrepancies in the Pradmudji report and the history that she provided to us. I also wanted to make sure I understood why she had a hysterectomy and that she had never had a diagnosis of endometriosis.
Q. And these were all things that you did

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yesterday; correct?
A. Yes.
Q. You didn't do any of these things before you issued your rebuttal report; correct?
A. Whenever I --
Q. That's a yes or no.
A. Besides my initial evaluation --
Q. You didn't call Mrs. Huskey --
A. I didn't. No. No.
Q. Let me just get my question out.
You didn't call Mrs. Huskey before issuing your rebuttal report --
A. No.
Q. -- to discuss any discrepancies between Dr. Pradmudji's examination and what Mrs. Huskey told you back in January; correct?
A. Well, I wasn't going to be disposed, and I wanted to make sure I had all of the history correct.
MR. SNELL: Move to strike. Nonresponsive.
A. I just want to specify. I don't normally call patients multiple times, but because this is my first deposition, I wanted to make sure I had all the answers and the most truthful and honest

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I possibly could, and provide that to you in the context of my opinion as a pelvic pain specialist.

And whenever I said I have a couple of questions about making sure that her pain was resolved prior to having the mesh placed, and that she was -- she'd never had a diagnosis of endometriosis, and that her hysterectomy was because of a fibroid and not because of intractable pelvic pain or whatever it was. I wanted to make sure that that was really very clear.

Q. BY MR. SNELL: And these are all things you did yesterday; correct?

A. In addition to asking her at the time of my medical exam, I wanted to make sure I was very clear when I came in here and talked to you about the Pradmudji report today. So I did that yesterday. It was a few simple questions, and I felt more confident in feeling I'm giving the appropriate and correct representation. I mean, I was the one who asked to see if I could speak to her again.

And, you know, in my own clinical practice, if I have a question that may affect a patient's care or an intervention or something that I was going to do and I wanted clarification,

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absolutely, I would call the patient.

Q. When you saw the discrepancies between what you reported in your history as recited by Mrs. Huskey compared to Dr. Pradmudji --

A. Right.

Q. -- you saw those discrepancies before you issued your rebuttal report, I take it?

A. I did.

Q. And did you know -- but you didn't call Mrs. Huskey at that time; correct?

A. I didn't know it was an option.

Q. Did you ask anybody if it was an option?

A. I did not.

Q. Okay. Did you take any notes during this conversation with Mrs. Huskey that occurred yesterday?

A. I did not.

Q. Was anybody else present besides you --

A. No.

Q. -- and Mrs. Huskey on the telephone?

A. No. My two-year-old was in the other room.

Q. Have you ever corresponded with any of Mrs. Huskey's medical providers, be they doctors, therapists or --

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A. No.

Q. Did you bring any documents here today to your deposition besides your rebuttal report and your updated curriculum vitae, which we've now marked as an exhibit?

A. No.

Q. Did you take any photographs during your evaluation of Mrs. Huskey?

A. No.

Q. Were there any tests that were performed during your evaluation of Mrs. Huskey?

A. Any diagnostic tests?

Q. Yes.

A. Well, the physical exam.

Q. Are there any other types of testing performed during Mrs. Huskey's exam?

A. Are you referring to something -- I guess, no. I mean, in the physical exam we perform multiple tests and evaluations of her back, sacroiliac joint, the vagina, the assessment of the nerves of the vagina, an assessment of the -- her response to pain from the vagina. I mean, all of those were performed during the physical exam, but as far as a diagnostic block or an invasive procedure in our clinical setting, and we wouldn't

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do that normally, anyway, in a new patient setting.

Q. For example, there were no EMGs done on her nerves; correct?

A. No. However, we don't -- even if I have someone who has a neuropathy of the pelvis, it is very difficult to assess the terminal branch of the nerves that may be inflamed, which is the terminal branch of the pudendal obturator, the genitofemoral. So for those specifically, we didn't assess those.

Q. Other than the physical exam, there were no types of diagnostic procedures performed on Mrs. Huskey at the time of your evaluation; is that correct?

A. Well, there were no diagnostic procedures. Her physical exam was abnormal, grossly abnormal. So she had a positive response to the Q-Tip in the vagina, which can be a correlate of increased pain sensitivity. She had a significant tenderness in that left side of the vagina. There was a palpable lesion on the left vaginal sidewall that was painful and possible scarring or residual mesh heading off to the obturator foramen.

I mean, it was very clear that she was completely unable to have penetrative vaginal intercourse that would be comfortable by any stretch

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of the imagination. While she did have pelvic floor tension myalgias, we were able to place a specula exam with discomfort associated. There was no erosive mesh seen, but her exam was not normal.

MR. SNELL: Move to strike, nonresponsive.

Q. BY MR. SNELL: Other than the physical exam, there were no types of diagnostic procedures performed on Mrs. Huskey at the time of your evaluation; is that correct?

A. I believe a physical exam is diagnostic. We did not do any additional diagnostic procedures other than a thorough physical exam.

Q. So that was my question.

Other than the physical exam that you performed on Mrs. Huskey, there were no other diagnostic procedures performed on Mrs. Huskey at the time of your evaluation on January 11th, 2014; is that correct?

A. Correct.

Q. Okay. At the time of your evaluation, you did not find any evidence of erosive mesh; correct?

A. She had scarring on the left vaginal sidewall. I did not unroof that in the clinic to

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find out if it was scar tissue or residual mesh.

Q. At the time of your evaluation on January 11th, 2014, of Mrs. Huskey, she did not have a mesh exposure?

A. No mesh exposure seen in the vagina.

Q. Was there any mesh erosion seen in the vagina at the time you evaluated Mrs. Huskey on January 11th, 2014?

A. No. But she had had a large mesh excision procedure prior to that.

MR. SNELL: Move to strike after "no."

Q. BY MR. SNELL: This palpable lesion on the left side of her vaginal wall --

A. Yes.

Q. -- explain to me where that was.

A. So left vaginal sidewall. I mean, basically heading out into the obturator process. So you basically go around the pubic rami. I mean, it was pretty -- probably 4 centimeters into the vagina. Both myself and Dr. Steege were able to palpate it. It reproduced her pain. I did not see any mesh exposure associated with this lesion. It was basically in the area of the obturator internus when we did our exam.

MR. SNELL: I'm going to move to strike

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that.

Q. BY MR. SNELL: Let me see if I can give you an instruction. Perhaps this will help.

If I ask you a question about Dr. Steege --

A. Um-hum.

Q. -- feel free to answer it about Dr. Steege. What I don't want is Dr. Steege did this or that thrown into your answers because I'm here deposing you. I've already deposed Dr. Steege.

A. Right.

Q. And I'm not -- if you can't answer a question because you feel you have to rely on Dr. Steege, that's important. Let me know that. But if I'm asking you -- for example, you just testified there was a palpable lesion on the left side.

A. Right.

Q. You know, can you describe for me where that was?

A. Which I did.

Q. Okay. But then you threw in a comment about Dr. Steege found it also.

A. Well, I wanted to make sure --

Q. I'm not interested in that.

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A. All right. Then --

MR. KUNTZ: You can answer the question however you want. Don't listen to that. Answer every one.

MR. SNELL: Jeff, you --

MR. KUNTZ: No. You don't need to tell her how she can answer questions, Burt. She can answer whatever way she wants to.

MR. SNELL: Okay. That means -- look. We'll be here forever then.

MR. KUNTZ: It's fine. You got 7 hours. We'll be here. You can answer whatever you want -- you can't sit here and tell her which way or not to answer a question. She's been responsive. She's been polite. And she's asked you to clarify when you can. And when you clarified, she answered your question. If Dr. Steege was there, and --

MR. SNELL: I don't care if Dr. Steege was there.

MR. KUNTZ: I don't care what you care about. She can answer the question however she wants.

MR. SNELL: I'm interested in this doctor.

MR. KUNTZ: He was there. She's telling

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you the truth about what happened on that date and he was there and she can answer --

MR. SNELL: It has nothing to do with my question. It has nothing to do with my question.

MR. KUNTZ: Then ask a better question, but don't sit here and lecture her --

MR. SNELL: I'm not lecturing her.

MR. KUNTZ: -- on how she can answer a question.

MR. SNELL: I'm not lecturing her at all.

MR. KUNTZ: Ask if she can -- okay.

MR. SNELL: I'm not lecturing you. I'm not interested in Dr. Steege, though.

MR. KUNTZ: But he's there.

MR. SNELL: I'm interested in your opinions.

MR. KUNTZ: He's part of the story.

MR. SNELL: I don't care.

MR. KUNTZ: You can't control that.

MR. SNELL: Jeff, I deposed him. He is not a rebuttal expert.

MR. KUNTZ: That's fine.

Q. BY MR. SNELL: Is Dr. Steege a rebuttal expert in this case?

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A. No.

Q. Who is the rebuttal expert in this case for the plaintiffs?

A. I am.

Q. So I'm asking you about you and your exam.

A. Okay.

Q. Okay. The palpable lesion on the left side of Mrs. Huskey's vaginal wall that you found at the time of your evaluation --

A. Yes.

Q. -- was approximately 4 sonometers in.

A. It was approximately. I mean, I'd say -- I can look at the --

Q. And if you have to look at your report.

A. I have to look at my report.

Q. Feel free.

A. Oh. So I'm just guessing because this is a single digit exam which produced significant tenderness behind the pubic arch. Thickening of the left vaginal sidewall, mesh versus scar. And it was at the level of the obturator internus. So where we would go in and feel the obturator on the left vaginal sidewall is where we felt that thickening and scar.

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Q. What are you looking at?

A. This is my physical exam from the Steege report.

Q. Okay. Can I see what you're looking at?

A. You sure can.

Q. Just so the record is clear, you're looking at Dr. Steege's expert report and the part about the physical exam?

A. This is a physical exam that we performed together.

Q. And so Mrs. Huskey's evaluation begins at page 12 of Dr. Steege's report, and the physical examination you were referencing is from page 16 of the report?

A. Yes.

Q. And there was no lesion noted in the Steege report; was there?

A. I'm saying lesion as far as thickening. I'm using that term interchangeably.

Q. Show me where on page 16 you were referencing.

So under the gynecologic examination on page 16 of Dr. Steege's report, the second paragraph, the very last sentence, which reads, "Thickening of the left vaginal sidewall noted," is

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what you were referencing?

A. Yes.

Q. Possible mesh versus scar?

A. Correct. That reproduced her pain.

Q. What was Mrs. Huskey's total vaginal length at the time of your evaluation?

A. It was 7 centimeters. I believe that's what we found. It's from the hymenal ring to the vaginal apex. And so performed without Valsalva and without a speculum.

Q. Okay.

A. Occasionally there can be discrepancies in vaginal length during the measurement, depending on which apex you place a Q-Tip.

Q. So you mentioned you had spent approximately 50 hours on the Huskey case?

A. Yes.

Q. Can you break that time down for me, beginning with your first work on the case?

A. This will be a gross estimate, but my travel and time in North Carolina, my initial visit with her, the physical exam, the discussion after the physical exam, the review of her medical records, my individual -- or my history that I shared with Dr. Steege, the review of the

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literature. I have not billed for any of this time. I'm giving you an estimate. Approximately 10 hours with my counsel for depo prep. And then my preparation yesterday, including the phone call with her and this morning for the deposition, including the deposition.

Q. Okay. So altogether -- back up.

For your travel time to and from North Carolina, are you compensated for that?

A. The -- I don't charge when I'm asleep. So they covered my flight and then my time that I'm working in North Carolina and my flight home. So I --

Q. So how many hours altogether were spent in connection with you going out to North Carolina, evaluating Mrs. Huskey and then returning back?

A. I also saw multiple other patients during that visit. But the flight, including the connection, is approximately 6 hours of travel time.

Q. So you saw multiple other plaintiffs from the litigation --

A. Yes.

Q. -- at the same time as Mrs. Huskey?

A. Correct.

Q. And when you see multiple plaintiffs

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from litigation on the same trip, how do you allocate your travel expenses? Do you break it down by a fraction?

A. I haven't billed for these. So I don't know how I'm supposed to do that. I'm going to provide my time. And then they can divide 12 hours of travel time among 6 of the patients.

Q. Your examination of Mrs. Huskey, including talking to her, the physical --

A. And then speaking with her afterwards.

Q. -- and then speaking with her afterwards?

A. Probably 2 hours. And then not including a review of her medical records.

Q. That's what I'm going to get into next.

So your examination of Mrs. Huskey was about 2 hours?

A. Um-hum.

Q. Is that a yes?

A. Yes.

Q. How long did it take you to review her records?

A. I did a thorough review of her records. 10 to 12 hours.

Q. Okay.

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A. And that was just a single time. I reviewed them again yesterday.

Q. The literature you -- strike that.

The literature review that you mentioned --

A. Um-hum.

Q. -- when did you do that?

A. I mean, I've done that throughout the entire process. So I don't know how you want me to allocate reading hundreds of articles or being familiar with them to one patient.

Q. You can't do that?

A. It would be a guess, no.

Q. So when you reviewed this literature, it's in your connection -- strike that.

When you reviewed this literature you testified about, it was in connection with your role as an expert for plaintiffs in multiple cases. Is that correct or not?

A. Correct. I reviewed additional information from Mrs. Huskey.

Q. What specific information or materials did you review specific to Mrs. Huskey besides her medical records?

A. Right. Well, I've reviewed multiple

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randomized controlled trials on the TVT-O. I've familiarized myself with the product. That was specific to Mrs. Huskey.

Q. And how --

A. I reviewed --

Q. Sorry. Go ahead.

A. -- Dr. Pradmudji's opinions. Wrote my rebuttal.

Q. And so how long did it take you to write your rebuttal report?

A. Well, I reviewed her entire -- her opinions. And so I want to say 6 hours.

Q. Okay. And this literature and -- review of randomized control trials, things like that, you -- I think you said you couldn't really estimate or break it down. So I'll move on.

You had 10 hours of deposition prep yesterday?

A. 10 hours total.

Q. Total.

A. Of the depo prep. And then yesterday I re-reviewed her medical records. I reviewed Steege's deposition and Pradmudji's deposition. And part of this is my own inexperience in providing a deposition. I wanted to understand how it worked,

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and I asked to see some of them.
Q. The --
A. And then my day today with the deposition. So waking up, reviewing.
Q. How did you prepare for the deposition? And by that I mean the 10 hours you identified.
A. Um-hum.
Q. What did you do? Strike that. That's a bad question.
What did you do to prepare for your deposition that took you the 10 hours that you estimated?
A. Went through the notice to take deposition thoroughly. I reviewed the depositions of Pradmudji and Steege. I asked really how this would go. So I wanted every detail from the beginning of the day to the end of the day. I wanted to know how you were going to ask me questions. And I -- I just had a lot of questions about this being my first deposition.
Q. Who did you meet with, if anyone, to prepare for your deposition?
A. I met with Jeff twice. And then I met with Margaret, Ed, and Fildelma.
Q. When did you meet with Margaret, Ed, and

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Fildelma.
A. Was that the 17th of June or July? June. I don't remember.
Q. Can't be July.
A. Can't be July. Definitely June. I believe it was the 17th of June.
Q. And that was about the Huskey case?
A. Yes.
Q. And you met with Mr. Kuntz twice to prepare for the Huskey case?
A. Yes.
Q. Are you currently under a deposition notice or schedule to testify --
A. No.
Q. -- in any other litigation cases?
A. No.
MR. SNELL: Let's take a break.
(Recessed from 11:46 a.m. to 12:08 p.m.)
Q. BY MR. SNELL: Back on the record. Exhibit 2 we marked as your rebuttal expert report.
A. Yes.
Q. And that's your final expert report in this case; correct?

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A. Yes.
Q. And that contains all of your opinions in this case; correct?
A. Correct.
Q. When you saw Mrs. Huskey on January 11th, 2014, was her husband also present in the room at the time of your history?
A. I don't believe so, no.
Q. Was Mrs. Huskey's husband present at the time of your examination of Mrs. Huskey?
A. No.
Q. Do you recall if he was -- strike that.
Do you recall Mr. Huskey was present at all on January 11th, 2014?
A. I don't remember seeing him.
Q. You don't remember talking to him at all?
A. No.
Q. Do you have a recollection of ever speaking to Mr. Huskey?
A. No. No. Hum-um. I really don't remember.
Q. When did you first review Dr. Pradmudji's deposition?
A. Her deposition or her opinions?

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Q. Her deposition.
A. Deposition. I reviewed it yesterday.
Q. When did you first review Dr. Pradmudji's expert report?
A. I reviewed her report in mid-April, whenever it was emailed to me.
Q. When did you first review Dr. Pradmudji's report regarding her independent medical examination of Mrs. Huskey?
A. Is that separate from her opinion? I don't know if I received that.
MR. SNELL: I'll go ahead and mark it just so we're clear.
THE WITNESS: Sure.
(Exhibit 4 marked.)
Q. BY MR. SNELL: Doctor, I've handed you Exhibit No. 4, which I'll represent is Dr. Pradmudji's IME examination for Mrs. Huskey which was performed April 11th.
Have you seen this document before?
A. Yes, I have.
Q. Okay. When did you first see Dr. Pradmudji's IME report concerning Mrs. Huskey?
A. Definitely after April 11th. I can't tell you the exact date, but I have seen it.

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Q. Did you see Dr. Pradmudji's IME report in preparation for your deposition?
A. Not specifically.
Q. Do you know if you had read Dr. Pradmudji's IME report of Mrs. Huskey before you issued your rebuttal report on April 11th, 2014?
A. I believe I did.
Q. Would you have letters of transmittal or emails that show when you receive certain case materials, including medical records and reports?
A. That would be easier than my memory to document, yes.
Q. So I'll ask --
A. That's fine.
Q. -- that the letters of transmittal and the emails providing you with Huskey case materials from the outset of reports, medical records, depositions be provided, be produced.
A. Yes.
Q. Those will be a more accurate recitation of the time when you received these materials than your recollection today?
A. Agreed. Yes.
Q. The medical literature, the randomized control trials you looked at in connection with

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Mrs. Huskey's case --
A. Um-hum.
Q. -- how did you receive those articles?
A. It was a compilation of my own literature search, as well as the ones -- articles that have been provided to me in a database.
Q. What's the database where these articles are provided to you?
A. It's an email or emailed into a drop box with access to literature pertaining to mesh.
Q. Do you have all the materials that you reviewed here with your deposition?
A. No.
Q. You didn't bring your case file for Mrs. Huskey?
A. Not my specific case file, I do not.
Q. Okay. Is there any way you can get that?
A. All of the -- a list of all the articles I reviewed.
Q. No. I mean your actual case file. The records you looked at, the literature, you know, whatever your Huskey case file would be.
A. I think it --
Q. Can we get it here today?

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MR. KUNTZ: It's all electronic.
A. It's all electronic.
MR. KUNTZ: I can get you everything we sent her.
A. Like the medical records and then the --
Q. BY MR. SNELL: Yeah. One of the things we asked be produced at this deposition is your case file on Mrs. Huskey.
A. Okay.
Q. So have you made any notes or notations or highlighting, any -- any type of writings on her records or any of the literature --
A. No.
Q. -- or the documents you reviewed?
A. Everything was electronic. So the only additional writing I wrote was the creation of the rebuttal.
Q. Okay. Before you saw Mrs. Huskey on --
A. January 11th.
Q. -- January 11th, 2014, what, if anything, did you know about her?
A. I knew nothing about her.
Q. Am I correct then that Dr. Steege had not provided you with an overview of what her medical or surgical history was before you went in

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to do your history of her?
A. Correct. We did not discuss that.
Q. So essentially you went in to take your history from Mrs. Huskey cold, without any information or knowledge about her?
A. Yes.
Q. And you relied on what she told you?
A. No. I mean, I used the combination of the information I queried her on during her history.
Q. Um-hum.
A. And then as well as the -- her medical records.
So as far as exact specific dates of procedures, I referred to her medical records.
But she appeared to me to be a thorough and appropriate historian and was able to provide at least her -- every detailed report of her pain since the excisional mesh procedure.
Q. What about her pain that predated her mesh insertion? Did she bring you a thorough history of that?
MR. KUNTZ: Objection. You can answer.
Q. BY MR. SNELL: You can answer.
A. Okay. Sorry.
She -- we -- so very specifically,

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because this is -- very specifically I asked if she had any episodes of sexual-related pain prior to the mesh placement that were similar to the pain she complained of at her present interview in January. She gave a detailed report of her experience in November and December of the previous fall. She noted resolution of her left lower quadrant pain and suprapubic pain, following her colonoscopy prep when she was hospitalized. She said that for some reason that had resolved her pain.

She reported that she had had previous urinary tract infections that had been treated and the pain was resolved. And overall she reported that she had a fulfilling and non-painful sexual relationship with her husband.

Q. BY MR. SNELL: At the time you took your history, though, you didn't have a grasp on those medical records to know whether she was being accurate or truthful; correct?

A. I mean, she was a good historian. So I believe that she was being truthful.

Q. You accepted what she told you at the time of your history you took from her in January of 2014; correct?

A. I did.

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Q. And you hadn't had the benefit of having seen her and reviewed her records in detail before seeing her, such that if there were any discrepancies, you could query her about those; correct?

A. Correct. Discrepancies regarding the dates, I did. I can't recall specifically if there were any, but I definitely would resort to the medical record. I reviewed the medical record, though, shortly after seeing her, during my time in North Carolina. So it would be a way I would normally put together a detailed history and physical examination of a patient I would see in a clinic.

Q. What percent of your time in your practice is spent treating patients?

A. I am a clinical practitioner. So all of my time. Do you want a breakdown of my week?

Q. Yeah. Let's do that. Maybe that's a little better.

A. Be easier to --

Q. That's no problem.

So can you tell me about your normal week, and if there's teaching or lecturing --

A. Okay.

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Q. -- involved, can you add that in?

A. Sure. So a normal week, I am considered 100 percent clinical. Though I do have a full day of administration time. So I have 80 percent hands-on patient care throughout the week. Monday, I have my GYN pain clinic in the morning and in the afternoon.

Tuesday I'm in the operating room.

Wednesday morning, I have a half day of administration time. Wednesday afternoon I have a clinic.

Thursday morning, I have a clinic. Thursday afternoon I have administration time.

And Friday I'm in the operating room.

I do provide lectures to the residents occasionally during their didactic period, which is Friday afternoon, although because this lands on my -- during my operating schedule, it occurs once every few months. I also am a clinical teacher, so I routinely have some -- a learner in my clinic, such as a medical student, a resident, a visiting professor, and do a lot of hands-on teaching at that time. I travel nationally and internationally and speak on pelvic pain.

Q. The clinic you do on Wednesday

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afternoon, which clinic is that?

A. It's the same clinic I have every day. So it's a gynecology only pain clinic.

Q. Okay. And that would be the same clinic as you do for the half day on Thursday as well?

A. Yes. I do see about 80 -- I do see some routine GYN patients. But the majority of practice is -- is pain based.

Q. Okay. And when you do your surgery, where's that at?

A. On Tuesdays I'm primarily at the pain campus at University of Kansas. On Fridays, I'm primarily at an off-site hospital. Indian Creek campus. I do minor, more minor procedures there.

Q. The Indian Creek campus, though, is an affiliate or is a part of the university campus?

A. It is part of the university. It's just another hospital.

Q. What percent of your time is spent on litigation matters?

A. A very small percent. So it would be in my -- the hours I provided for the Huskey case, a small amount of travel outside of that for the independent medical exams, but it is in my off time.

Q. Did you review any Ethicon company

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documents in connection with formulating your opinions?
A. Such as? I mean, I haven't been to the web site and searched for any additional documents.
Q. Did you --
A. I did read the IFU. I'm familiar with it.
Q. I take it you mean the IFU for the TVT-O?
A. Yes.
Q. Did you review the IFU for the TVT-O before you issued your rebuttal report or sometime after?
A. I reviewed that in the process of this whole thing. I think it was before. I specifically reviewed that since.
Q. Did you review any other Ethicon documents regarding the TVT-O?
A. No.
Q. In formulating your report and opinions that you've memorialized in your expert report that's been marked as Exhibit 2 --
A. Um-hum.
Q. -- am I correct that the bases or sources of your opinions and information come from

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your evaluation and examination of Mrs. Huskey, her medical records, the TVT-O IFU, the medical literature that was given to you and that you searched on your own, and that's it?
A. In response to Dr. Pradmudji's opinion, yes. That's correct.
Q. Is there any other documents or categories of information you considered in forming opinions?
A. No.
Q. Okay. Have you ever met Dr. Pradmudji?
A. No.
Q. Did you review any of the other expert reports besides Dr. Pradmudji's report that were submitted on behalf of Ethicon?
A. I don't believe so.
Q. What was your involvement in the drafting and finalization of Dr. Steege's expert report in the Huskey case?
A. As far as we wrote the report together? Is that what you're asking? Did we write the report together.
Q. What was your involvement?
A. Okay.
Q. So my question is very basic and it's

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very broad.
A. Yeah. It's broad.
Q. That's how depositions work, and then I'll listen to you, and it may spur more questions. So let me just kind of clean it up and then ask a question.
A. Yeah. Um-hum.
Q. What involvement, if any, did you have in the drafting and finalization of Dr. Steege's expert report?
A. So in addition to both of us writing up our individual histories of the patients, our combined medical exam, both of us contributed to the report. We both drafted and added our pieces. And, I mean, really both edited it so that we didn't have too much duplicity of information. So --
Q. Is it your standard practice in these litigation matters to both draft and edit Dr. Steege's reports that are submitted under his name in his expert report?
A. These were designed to be from both of us. So I mean we both interviewed the patients. We both examined the patients and we both contributed to the report.
So I guess I don't know how these things

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normally or usually work, but this is my first experience with independent medical exam, and that's how we did this was together, with my mentor. We both have additional and unique training when it comes to these women who have very specific sexual health complaints. And I think it makes the report stronger that both of our evaluations are provided.
I mean also we were instructed to give one assessment, not two individual evaluations. So for this, this was a very usual thing that we did for all of our patients. We evaluated.
In a typical clinical setting, it's just not feasible.
Q. You and Dr. Steege were instructed to give one assessment; is that right?
A. To write one medical exam. We both entered it. We both edited. It's both of our opinions. But that's not necessarily why I'm brought into this case. I know that you've -- as you've said, you've deposed Dr. Steege, and my contribution is the rebuttal for Dr. Pradmudji.
Q. Are you licensed here in Missouri?
A. No. Kansas. I don't have a Missouri license.
Q. I'm confused.

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A. I know it's very confusing.
Q. I'm confused because we're here in Kansas City.
A. I know.
Q. Forgive my geographic confusion.
You're licensed to practice medicine in Kansas; correct?
A. Correct. I have also maintained my license in North Carolina.
Q. So your North Carolina license is still current?
A. It's still current.
Q. When you took your Ob/Gyn boards, did you pass them the first time?
A. I did.
Q. Are there any subspecialty board certifications or any other board certifications that you've ever sat for?
A. No.
Q. Any that you're intending on taking in the future?
A. As soon as I hurry up and write one for laparoscopy, I'll sit for those. And I have considered sitting for pain medicine boards. I just needed to complete my general boards first.

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Q. What percent of your time is spent doing research and writing publications and articles? And I just want to talk about for the last two years?
A. The last two years?
Q. Yes.
A. It's been very different. I was in a fellowship my last year in North Carolina. So it was very heavy. I mean, I had 20, 25 percent of my time was busy with research.
Since transitioning to a very busy clinical practice, it's my own time. And so I do it in the evenings, on weekends. Not unusual for people with a very heavy clinical volume.
Q. Okay. When you were doing your fellowship --
A. Um-hum.
Q. -- was that under Dr. Steege?
A. My first fellowship, yes, Dr. Steege and Dr. Zolnoun and Dr. Siedhoff.
Q. That was the advanced laparoscopy and pelvic pain; correct?
A. Yes.
Q. When you did that fellowship, can you tell me how was your time allocated between clinical, administrative, and other duties like

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writing publications?
A. It was very heavy clinically. So we were in the operating room at least three days a week. We had a clinical volume load of at least three half days of clinic a week. I also completed in the fellowship -- you complete a master's of science in clinical research, which is during that time. And, unfortunately, the way it worked out, our clinical load is such that a lot of our research time was also done in the evenings and on the weekends. I was also affiliated with and had the opportunity to work with the Center for Neurosensory Disorders there, and I continue to work with them. That's been some of my dysmenorrhea research, and continue to collaborate with many people that I met during my time in North Carolina.
Q. And then after that, that's when you did the anesthesia?
A. I did the anesthesia focus, GYN pain.
Q. And how was your time allocated there? You testified about 25 percent was research and articles. What was the other 75 percent?
A. So it was clinically my day -- my week was -- I was -- half the week I was an anesthesia fellow, and half the week I was a GYN attending.

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That means I would -- I did some surgical procedures, but because of my clinical volume with the other two pain practices, I was limited in the operating room. I had three half days of pain clinic, a full day of pain anesthesia procedures, usually a full day of surgery, and then research, I participated in a mesh pain clinic during that time.
Q. The mesh pain clinic --
A. Was during that year.
Q. What year is this?
A. 2013. That's when it was initiated.
Q. Okay. When in 2013?
A. I don't know the exact date, but it was -- it was --
Q. Do you remember if it was winter? spring? summer? fall?
A. Beginning -- I probably say it was like winter or spring of 2013 is when it kind of started getting -- or when it started being initiated. I don't have the exact dates.
Q. That's fine. So in the winter or spring of 2013 you began working?
A. I was still a fellow. During my fellowship, whenever I was with Dr. Zolnoun, she did a large volume of vulvar mesh patients in pain

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clinic. So it was collaboration between her and some of the urogynecologists to make the mesh pain clinic.

Q. So your best recollection is the mesh pain clinic was started around the winter or spring of 2013?

A. Estimate, yes.

Q. And that would have been about the time you would have begun working there?

A. Transitioning from my fellowship to another additional training.

Q. How often did you work in that mesh pain clinic?

A. Whenever I was a fellow, I was available on the Monday afternoons that it was run.

Whenever I did my additional fellowship, I often would -- I probably made it once a month to the clinic because of my other pain duties. But still, I mean every clinic was six plus patients and it would go into the evenings. And there were two providers, one from urogynecology, one from our pain clinic. It was a pretty -- pretty busy place.

Q. Was Dr. Steege --

A. No.

Q. -- involved in the mesh pain clinic at all?

A. No. He was not.

Q. Do you have any copies of the searches you did to locate the medical literature that you're relying upon for your opinions?

A. Do I have copies of the searches I did? Whatever I included in -- as far as referenced, I may have them on my PubMed database. Sometimes I make a clipboard or a file.

Q. Right.

A. So I can look. I don't have it off the top of my head, but I often do that whenever I am doing some research.

Q. Right. PubMed has some ability you can sort and download and put on your clipboard or e-file?

A. You have to make sure you move it off the clipboard or it erases. So I've learned that once or twice.

Q. So PubMed is the search engine you would use to do research?

A. Yes. Yes.

Q. Medical research?

A. Correct.

Q. If you can check and see if you have those articles that you searched and found.

A. Yeah.

Q. I know, you know -- did you download them to your bibliography on PubMed, or would you have just kept them on the clipboard?

A. No. I would have kept them. I can look. I have to go back to April.

Q. If you have those or can locate those, please, let Mr. Kuntz know?

MR. KUNTZ: Yeah.

MR. SNELL: I think. Let's take a lunch break. It's 12:40.

THE WITNESS: Okay. That sounds good.

(Recessed from 12:41 p.m. to 1:39 p.m.)

Q. BY MR. SNELL: All right. Doctor, we're back from a lunch break. Are you ready to proceed?

A. I am. Thanks.

Q. You mentioned that you had obviously had involvement in the drafting, and you had seen Dr. Steege's expert report.

My question is: Have you seen any other expert report by any of the other plaintiff's experts?

A. I mean, I think I have. I don't know the specific names. I think they've been provided, but I don't know if I actually read them or went into detail with them.

Q. You testified you read Dr. Steege's deposition; correct?

A. Correct.

Q. Did you read any of the other depositions of the plaintiff's experts?

A. They were -- there was a couple that were provided. I asked for Rosenzweig's. I did not read that, but I had it available to me. And there -- I think a couple more were provided. The only ones I read were Steege's and Pradmudji.

Q. Have you had any communications with any of the plaintiff's experts?

A. No.

Q. Have you exchanged any emails, written communication with any of the plaintiff's experts?

A. No.

Q. Dr. Iakovlev is a pathologist?

A. He is.

Q. He's one of the plaintiff's experts?

A. Oh, I didn't consider him as one of the experts. I know him just from a collaborative research.

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Q. You didn't read his report or deposition?
A. No. But I had emailed with him.
Q. About what?
A. About a project we had worked on together. An abstract that was submitted called The Pathology of Explanted Vaginal Mesh.
Q. There's no pathology in Mrs. Huskey's case. You're aware of that?
A. I'm -- I don't believe that it was included in our manuscript; correct.
Q. The abstract publications on this project, did you bring them to the deposition today?
A. They're available.
THE WITNESS: Do you have that?
MR. KUNTZ: Yeah. I thought they were sent to you. Can we go off the record for a second.
(Discussion off the record.)
Q. BY MR. SNELL: You mentioned Dr. Rosenzweig. Do you know him?
A. No.
Q. You never met him?
A. No.
Q. Have you ever met Dr. Iakovlev?
A. No.

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Q. Can a patient's pain levels change day to day?
A. Their perception of pain can be different day to day, yes.
Q. Is that something you see in some of your patients, even week to week that their pain perception changes?
A. Pain's affected by many things. So, yeah, it can be -- I mean, can their reported pain level be different day to day? I mean -- is that what you're asking?
Q. Yes.
A. Yes.
Q. Pain is a subjective complaint?
A. It is. It's considered the fifth vital sign that we use to assess patients.
Q. When you ask patients about their pain levels, do you use scales like rated out of a 1 to 10, 10 being the worst, 1 being no pain.
Do you use any methodology like that?
A. It's one way to evaluate the severity of pain.
Q. Is that something you employ in your practice?
A. Not consistently, but sometimes, yes.

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If a patient has pain, it would -- I mean, I would ask them if they could put it on a scale. It tries to -- what you're trying to do is provide some kind of measurement to guide the severity of pain and the distress it causes the patient.
Q. Can pelvic examinations of a patient who has pain exacerbate their pain?
A. If they have pelvic or vaginal pain, yes.
Q. You have your rebuttal report in front of you?
A. I do. You want me to look at something?
Q. Yeah. Let's go to the second page where you set forth the rebuttal opinion No. 1 regarding Dr. Pradmudji's opinion that Mrs. Huskey's levator spasm is not caused by the TVT-O because it is not in the same location.
Are you there?
A. Um-hum. I see that.
Q. You write in the first sentence -- and I'm going to move towards the end of it -- that "the vaginal pain appeared posterior to Dr. Pradmudji."
A. Um-hum.
Q. Correct?
A. Yes.

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Q. Okay. Do you agree or disagree with that location of being a posterior pain?
A. Which pain?
Q. The posterior pain that Dr. Pradmudji noted.
A. I mean, even I noted that on her exam. She has levator muscle spasm, but that's part of pelvic floor tension myalgias, but that's not necessarily -- that's not the exact -- that's not the same pain as the left vaginal wall pain that she feels during intercourse. But with palpation, that was consistent with my exam also. She had some tenderness of the levator muscle.
Q. What I'm trying to understand is the vaginal pain that Dr. Pradmudji noted being posterior, do you agree or disagree with that?
A. She does have vaginal pain posterior in addition to her mesh-related pain.
What my opinion was here was that Dr. Pradmudji said that her spasm was not caused at all by the mesh procedure, and I think that's incorrect.
Q. And where you say the spasm is occurring in the entire pelvic floor muscular, that's what you're talking about?

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A. Yes. Um-hum.
Q. What was that based on?
A. That's how these muscles work. I mean, very -- so the levator muscle complex is not just -- it's not like pointing to the bicep where you say that's exactly where your pain is. It's an entire dome of muscles that are in the pelvis that help support all of the pelvic structures.
Yes, she has some posterior tenderness. Just because -- the vagina is a tube. Just because you have pain here -- that means that whole muscular tube -- doesn't mean that can't be caused from something from the left vaginal sidewall. Can be caused by the interior, the bladder, the bowel. I mean, all those things can cause this entire complex to spasm. So just saying that someone has a little bit of posterior pain here, you cannot conclude that it wasn't caused by something that happened here or scarring or injury. I mean, this is not that far away. This is -- the way these muscles work is a contracture in response to irritation or pain or injury.
Does that make sense?
Q. Well, the pelvic muscles can contract for numerous reasons beyond those you just

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elicited -- enumerated; correct?
A. They can.
Q. When I -- the spasm, you opine, which is occurring in the entire pelvic floor musculature, that's based on your January 2014 examination of Mrs. Huskey?
A. Yes.
Q. Turn to the next page at the top where you talk about Dr. Siddique's operative report.
A. Um-hum. I see that.
Q. And the mesh was dissected up the vaginal sidewall, and you note retracting behind the pubic bone.
Are you there with me?
A. I am.
Q. Did you read Dr. Siddique's testimony about that retracting behind the pubic bone?
A. I only read what was in his operative report.
Q. You haven't read Dr. Siddique's deposition?
A. No.
Q. Have you read any of the deposition of any of Mrs. Huskey's treating doctors?
A. I did look at Colleen Fitzgerald's.

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Q. She's a therapist?
A. She's a physiatrist.
Q. Did you ask for all of the depositions of Mrs. Huskey's treating doctors?
A. Whatever was not in the medical record, I didn't ask for anything additional except for some depositions to read prior to my own. So I'm not sure if I received all of them, but I did not read them if I did.
Q. Okay. So you don't know what Dr. Siddique testified to about when the mesh retracted behind the pubic bone?
A. I know it was in his operative report and what he described. So, you know, the mesh -- in his excision of the mesh to the vaginal sidewall. So I know he did not completely excise the mesh, and there was an extensive procedure. But he was able to get a large portion of it out, and that was just described from his operative report.
Q. Beyond the operative report, though, you don't know anything about Dr. Siddique and what he saw?
A. I mean, the operative report is a pretty good description of what occurred during the surgery. But I didn't see anything else. I mean, I

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didn't read any additional description of what occurred.
Q. When did you get Dr. Fitzgerald's deposition?
A. I have to look at my email. I can provide that for you.
Q. Do you know if it was before or after you did your rebuttal report?
A. Oh, it was after. It was whenever I was assigned a date for the deposition.
Q. A little further under there you talk about Dr. Pradmudji, and you take a quote out of her deposition where it says, "I'd have to look at the anatomy book because I don't have it memorized."
Do you see where I'm at?
A. I do.
Q. And did you read Dr. Pradmudji's entire deposition?
A. Not every word.
Q. Do you know if Dr. Pradmudji testified anywhere else in her deposition about the different pelvic floor muscles?
A. I don't know all of the details.
Q. What was your methodology for picking out one quote out of a 200-plus page deposition?

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A. I just thought it was kind of a -- if she's going to make a conclusion about a levator ani complex and make it one of her formal expert opinions but then couldn't describe what muscles lined the transobturator canal or foramen or how the levator muscles work in relation to the obturator and obturator internus, it just kind of surprised me.

Q. Let me see if I understand this.

Is it your testimony that Dr. Pradmudji doesn't know the muscles in the pelvic floor or around the transobturator area, and she didn't testify about that in her deposition?

A. No.

MR. KUNTZ: Objection.

Q. BY MR. SNELL: You're aware she testified about the different muscles in her deposition; correct?

A. I would have to look at her deposition. I know she did discuss her pelvic floor muscles. I just said it's really interesting how she doesn't think the levator ani spasm could be caused from the transobturator tape, which goes through where the levator ani actually inserts, one of the insertion points -- how that would be related in any way,

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shape, or form. It just surprised me.

Q. You believe that Mrs. Huskey had levator ani spasm?

A. She does.

Q. Dr. Pradmudji believes she has those spasms.

A. That are not caused by the mesh. That's where we disagree.

Q. So you both agree that there are levator ani spasms, but you disagree as to the cause; fair?

A. That is fair.

Q. Mrs. Huskey has SI joint dysfunction; correct?

A. She does.

Q. She's had that even before her mesh was put in; correct?

A. Correct.

Q. Was she wearing her SI brace when you saw her in January of 2014?

A. Again, I don't recall. I don't remember.

Q. Did you record that anywhere?

A. I would have to look at my record. I think that she had one and that she had used it intermittently with some relief of her pain. But I

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don't -- I don't know if she was wearing it whenever I saw her.

Q. And are compliance with -- strike that.

Can a patient's compliance with wearing their SI brace effect their SI pain levels?

A. Their SI joint pain may -- if it makes her pain better, then it might do that.

Q. What's your understanding of the effect that her SI brace had on her pain?

MR. KUNTZ: Objection.

A. I'm assuming she had a brace and she wore it. She would only wear it if it was effective or at least reduce some of her pain. Now --

Q. BY MR. SNELL: Did you ask her during your history of her when she had been first prescribed that SI brace?

A. I don't recall.

Q. Did you ask her how often she wore her SI brace within the week before she saw you and you evaluated her?

A. The SI joint is a major weightbearing joint in the pelvis or the --

MR. SNELL: I'm going to move to strike.

A. But --

Q. BY MR. SNELL: My question was about the

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week before.

A. But my answer goes to whether this related to her mesh-related pain, because she -- even on my exam, she had SI joint pain and tenderness, but it's different than the mesh-related pain that I believe caused her levator spasm.

Q. You agree that Mrs. Huskey had SI joint pain?

A. She did.

Q. Now, my question -- and I'm going to move to strike your earlier answer. I don't think it was responsive.

My question was this: Did you ask Mrs. Huskey about her compliance in wearing her SI interface in that week before she came to see you and you examined her?

A. I don't believe I did.

Q. Do you know what Mrs. Huskey had been doing in the week before you saw her and examined her?

A. The details of her day-to-day life the week before I saw her, no.

Q. Do you know if she had had any evaluations or pelvic examinations or procedures before -- in the week before you saw her?

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A. I don't know.
Q. If she had had pelvic examinations in the week before you saw her, would that have been of interest to you?
A. No.
Q. If she had had a pelvic examination and a vaginal examination the day before you saw her, would that be of interest to you?
A. It would be helpful to know if she was seeing another provider. But I guess I don't know what your point is.
Q. You earlier testified that pelvic and vaginal exams of a patient with pain --
A. Right.
Q. -- can exacerbate their pain.
A. But normally those muscles -- you can have a woman who has no pelvic floor muscle dysfunction, and, while it wouldn't be pleasant, probably perform 100 speculum exams on her, and she wouldn't have a levator ani spasm.
So if a person has one exam -- I just want to make sure I understand you. Has one exam and then comes and presents to another doctor a day or two later, a person who would have a normal pelvic floor wouldn't be tender. That would not

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be -- that exam would still be abnormal. Am I making sense?
Q. I think I understand what you're saying.
A. Okay. So it would just be -- it would just be --
Q. Mrs. Huskey doesn't have a normal pelvic floor; correct?
A. She doesn't. She has a pelvic floor that is hypertonic, painful.
Q. Right.
A. She has residual mesh in her pelvis. She has inflammatory response. She has levator ani spasm. Not normal. Agreed.
Q. So Mrs. Huskey, if she had seen somebody the day before she saw you and had a pelvic and vaginal examination, considering she's got pain, she's got spasms, that could affect her presentation to you the following day?
A. She may be a little bit more sore, yeah, but not a normal patient.
Q. On the bottom of page number 3, where you're talking about the levator spasm --
A. Which one?
Q. No. 3.
A. No. 3, okay. Yes.

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Q. It says, "According to Dr. Pradmudji, the levator pain that has occurred since the mesh was explanted was precipitated on speculum exam"; correct?
A. That is what Dr. Pradmudji said, yes.
Q. And a speculum examination can cause those muscles to go into spasm; right?
A. Not in someone who did not have pelvic floor dysfunction to begin with.
I've never seen -- the way I interpreted this was that someone who had a normal pelvic floor, you put a speculum in, I have never seen someone have a chronic levator spasm from a speculum exam. That's how I interpreted this.
So I just wanted to clarify. Obviously someone who has levator ani pain and you barely touch them and you put a speculum in, that's going to cause pain and maybe spasm, but not in a person who does not have pain and spasm -- a painful vagina.
Q. Did you think that Dr. Pradmudji was just talking about a hypothetical patient without pelvic floor dysfunction?
A. I thought she was talking about how -- the way I interpreted this was that the speculum

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exam is what caused her to have chronic pelvic pain. That's the way I interpreted this, and that is incorrect. I've never seen it happen. I've seen thousands of women with chronic pelvic pain. I've never seen the examination of a normal pelvic floor that is not responding to a chronic response, a chronic painful response go into a six-month long spasm. That's how I interpreted that.
Q. So it could be that you just misinterpreted Dr. Pradmudji then?
A. Per Dr. Pradmudji, the levator spasm was precipitated by a speculum exam. I interpreted that as a chronic levator spasm.
Q. Well, you would agree that the levator -- the levator -- strike that.
You would agree that her levator spasms were triggered by the speculum exam? In her, I'm talking Mrs. Huskey.
A. They were worsened by it.
Q. Okay. You're aware that's in the records, the medical records in this case?
A. That, yeah, when she went to see -- are we talking about the event with Dr. Siddique, postoperative?
Q. Okay. For six weeks --

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A. But that did not -- but she didn't have anyone touch her pelvis for six weeks. She didn't have vaginal intercourse, because we know she can't still have that. We know she didn't have any additional exertion. So whenever he did go and put a speculum in, it was painful.

Do I think that's what caused her six months of chronic pelvic pain? I don't. I think they were already tight, and that may have been kind of a -- an additional trigger. But in someone who had a normal pelvic floor, that would not have happened.

Q. So the insertion of the speculum was what triggered her levator ani spasm; correct?

A. I don't think so. I think it was tender and it caused a painful response. I've just never seen that happen. In all the thousands of women I've treated, I've never had someone who had a normal pelvic floor and you put a speculum in and they have chronic pain afterwards. I've never seen it.

Q. Is it your testimony that Mrs. Huskey had a normal pelvic floor at the time this examination was done?

A. I don't think she does. I don't think

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she had a normal pelvic floor after the excision of the -- she didn't have a normal vagina after the mesh was placed. She didn't have a normal pelvic floor after a morbid excision of mesh with residual mesh in her vagina. So I don't think that's a normal pelvic floor.

Q. At the top of page 4, you're talking in the first paragraph about -- strike that.

Page 4 in the second paragraph, where we're talking about neuropathic pain.

A. Yes.

Q. Okay. Am I correct that when you examined and evaluated Mrs. Huskey, you could not document a single nerve injury?

A. Meaning I don't think she has a specific nerve injury, necessarily. I also didn't do -- if I was going to try to diagnose a nerve injury, I'd do a diagnostic nerve block, and we did not do that.

What she did have was generalized sensitivity of the vagina, as well as an abnormal pain response with pinprick sensation.

Q. But you didn't do any further testing to determine whether it was a nerve injury?

A. We did not. But her exam was abnormal.

Q. Section 5, Dr. Pradmudji's opinion about

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the interstitial states.

You there?

A. I am here, yes.

Q. Did any of Mrs. Huskey's medical records before her sling placement state that she had or may have interstitial cystitis?

A. She had had some urinary symptoms and chronic urinary tract infections that had resolved. To my knowledge, she had never officially completed a pelvic organ prolapse questionnaire or was seen by a urologist or a urogynecologist who diagnosed her with interstitial cystitis or had any abnormalities on her cystoscopy prior to mesh placement.

Q. What was the questionnaire you talked about?

A. It's called a PUF Questionnaire. It's a questionnaire that we use to assess symptoms of interstitial cystitis.

Q. Can you spell that? Is it P-U-F-F?

A. P-U -- I think it is P-U -- it's an acronym. I don't know exactly what it stands for. A urologic assessment. It's used routinely in the literature for interstitial cystitis and painful bladder syndrome as diagnostic criteria.

Q. And did you give Mrs. Huskey this PUF

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Questionnaire?

A. I did not.

Q. And you didn't see one in her medical record?

A. I didn't, no. But I think that her bladder symptoms are not from primary interstitial cystitis necessarily. I think it's refractory to her mesh procedure, her chronic inflammatory response, scarring, pelvic floor tension. I don't think it just started one day as an interstitial cystitis, even if she did qualify.

The thing that's difficult with that questionnaire I described is a lot of people will screen positive, even if you don't have the constellation of symptoms that support a diagnosis of interstitial cystitis. So you have to use it with caution because I probably would screen positive, or if we drink too much coffee, we might screen positive to urinary urgency. So it needs to be used in an entire evaluation of the patient, not alone.

Q. What are the different categories on the PUF Questionnaire that Mrs. Huskey would have likely had positive screenings for besides the urinary tract infections and the urinary symptoms?

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A. You know, I'd have to look at it specifically. I mean, I've used it for my research standpoint. It's going to look at how often people void, urgency, pain with voiding. I'm guessing here. I'd have to actually look at the questionnaire.

Q. Before her sling placement, Mrs. Huskey had pain to her bladder?

A. She had a short-term episode of suprapubic pain prior to her sling placement.

Is that the episode you're talking about in November or December of 2012?

Q. That's the only complaint of pain before the sling?

A. She had had urinary tract infections that had been treated that were documented in her medical record.

But as far as six executive months of suprapubic bladder pain that would support a diagnosis of interstitial cystitis, no.

Q. Interstitial cystitis, that's a clinical diagnosis; correct?

A. It is. There are also some findings on cystoscopy that occur on patients who have interstitial cystitis, including Hunter's ulcers and

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a small contracted bladder. So low bladder compliance, which you can diagnose on cystoscopy.

Q. And which percent of patients with interstitial cystitis has the Hunter's ulcer?

A. 10 percent is the estimated number.

Q. So that finding in and of itself is not conclusive for interstitial cystitis?

A. No. But it's really the only reproducible objective finding.

Q. And that only occurs in about 10 percent of women who have interstitial cystitis?

A. That's the estimate, yes. I believe she had two normal cystoscopies. After -- or by Dr. Siddique.

Q. So if a woman has interstitial cystitis because of the prevalence of these ulcers being 10 percent on cystoscopy, it's more likely than not those women wouldn't be diagnosed based on the cystoscopic findings?

MR. KUNTZ: Objection.

A. Well, there are other findings on cystoscopy that can occur, and I can't give you the exact percentile.

Q. BY MR. SNELL: Okay.

A. That would be the low bladder volume, as

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well as pain with bladder filling. So if this woman's awake and you're -- she may have pain earlier than a woman who doesn't have interstitial cystitis, as you fill her bladder. You may also have petechiae or inflammation of the lining of the epithelium.

After you fill it and then release it, you look back in the bladder. That's part of the hydrocystoscopy, hydrodistention that can be performed, looking for small hemorrhages or petechiae that would say that the bladder was kind of stretched beyond it's capacity, even if it was at normal volume. So those are other objective findings that we use in addition to their clinical history.

Q. Do you know what the predictive value of those conditions are then?

A. Sorry. Can you repeat that? Predictive value?

Q. Well, so women with -- just so I understand, women with interstitial cystitis, you give them a cystoscopy. Only 10 percent of them are going to have this Hunter's ulcer?

A. Hunter's ulcers, yes.

Q. But you don't know the percentage of

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women who have interstitial cystitis that have these other findings that you just enumerated?

A. I can't give you a percentile, but I mean -- I can't estimate how many. But there's other things we look for, and that's one of the reasons we use the cystoscopy with hydrodistention.

Q. A cystoscopy with hydrodistention?

A. Right. So you fill the bladder. You basically fill the bladder to gravity. You raise a bag of normal saline or whatever you're using to fill the bladder. Approximately 80 centimeters of mercury -- or 80 centimeters squared above the bladder dome. So you just let it backfill. And in normal volume would be -- a gravity greater than 500 cc's or so. If you let it backfill to gravity, the normal volume would be 5 to 600 cc's without forcing it to fill. And so in some of these women you'd find a smaller compliance of the bladder. So you wouldn't get that easy going.

Q. Has Mrs. Huskey ever undergone a cystoscopy with hydrodistention?

A. Not to my knowledge.

Q. At the bottom of that page, you talk about the broad symptoms of interstitial cystitis, including suprapubic pain, bladder pain, dysuria,

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urgency, frequency, and concurrent urinary tract infections.
A. Recurrent is probably what I should say.
Q. Okay. Recurrent. There's a typo. I tried to correct it, but I was wrong.
A. There is. Into another typo.
Q. Okay.
A. That is the constellation of symptoms lasted more than six months.
Q. The symptoms lasting more than six months, has that -- where is the -- is there a guideline or something that says these have to last more than six months?
A. It's a chronic pain condition. So I -- I mean, a woman has that with a urinary tract infection that lasts three days. I would not call her having interstitial cystitis. So if a person has persistent chronic pain -- and as we mentioned earlier, my definition of chronic pain is more than six months -- then I would think that they would have symptoms consistent with interstitial cystitis.
Q. Before having her mesh -- strike that.
Before the TVT-O was placed, did Mrs. Huskey have urgency?
A. She had had some complaints of urgency.

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But I mean, that intermittent -- I mean, an isolated complaint of urinary urgency is not interstitial cystitis. When we're talking about these chronic pain conditions, it's a clinical diagnosis, and it's something that affects a person's quality of life.
And I mean, there may be -- I think that what we're doing here is we're taking some of these things out of context and we're trying to apply it to something that is completely different. She may have filled out a review of systems in her doctor's office in 1997 -- and I'm guessing, but I'm just saying anyone could have done this.
And if they had either a urinary tract infection or too much coffee or they didn't drink enough water, and at that time when you would fill out your review of systems, it's saying, do you a little bit of urgency right now, do you have this.
That's one of the problems with all of our chronic pain diagnoses is that we are not using a lot of questionnaires or validated questionnaires to help us decide when something was diagnosed, help us differentiate between the different types, help us decide what to treat them with. So an isolated marking on a review of systems 10 years ago saying that she had urgency one time and it resolved, not

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interstitial cystitis. That's not the way this disease works.
Q. Do you know before the placement of the TVT-O whether she had urgency that hadn't resolved?
A. I believe she had had a complaint of urgency prior to that. Yes.
Q. Is it your testimony that that, though, had resolved before her placement of TVT-O?
A. No. I think that when she saw Dr. Burkett she did have some urinary urgency.
Q. What's the difference between urinary urgency and urinary frequency?
A. The urgency is the feeling that you have to go. Frequency is actually emptying your bladder.
Q. Going a lot?
A. Right. But we don't even know necessarily what -- that's not quantified in any of this. Well, if someone feels like they go to the bathroom and they go, technically normal is voiding eight to ten times a day. But someone who voids ten times a day may feel like they're frequent, but that's not quantified, versus someone who voids four times a day and they feel they're fine, and that's probably not healthy, versus someone who always voids at an hourly basis when they're at their

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office because they drink coffee all day. And just because they void 14 times doesn't mean they have interstitial cystitis. That could just be part of their variance.
I know that Dr. Burkett didn't perform an entire evaluation or offer a questionnaire or do any diagnostic testing for interstitial cystitis before she placed the sling. And what I found and what I heard from the patient was that her urinary symptoms didn't really become problematic until after the excision or the second excision.
So I mean, I see where you're trying to draw some correlation, but I think that that is incorrect. And that if she does meet a diagnosis of interstitial cystitis now, it's secondary to a morbid surgical procedure from a mesh that was placed years prior.
Q. So you haven't ruled out interstitial cystitis then; have you?
A. On Mrs. Huskey, no, I have not. And you mean that just in general or cause of all of her pelvic pain?
Q. I mean that in general. I mean, you have not ruled out --
A. No. But --

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Q. -- that she doesn't have interstitial cystitis?
A. Could she? Yeah. Could she from the mesh? Yes. Could she from her intractable spasms of the pelvic floor? Yes.
That's how all of these systems work together. You get something inflammatory and irritating like a foreign mesh material in someone's pelvis, and then whether or not they might have initiated it -- but I know for sure that the morbid surgery of removing it, which is incredibly difficult and an sensitive procedure, causes significant amount of pain following that attempt.
Without complete removal of the procedure, foreign body, and leaving her incapacitated, unability to -- inability to use her vagina without pain, inability to have a normal sexual relationship with her husband. And this is what I'm hearing from the patient and what's supported in the medical records. These are the patients I see in my clinic.
And I don't have a lot of answers for them. It becomes --
MR. SNELL: Move to strike everything after, "No, but -- could she? Yeah."

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Q. BY MR. SNELL: So Mrs. Huskey may have interstitial cystitis?
A. And it may be from her mesh.
Q. I was going to give you that.
A. But you --
Q. Well, when I ask a question -- my question before was simple. You haven't ruled it out, and you gave me a long, long answer. That was a yes or no. So we can do this two steps.
You haven't ruled out interstitial cystitis in Mrs. Huskey's case; correct?
A. Correct.
Q. Mrs. Huskey could have interstitial cystitis, but if she does, you would believe that it would be because of her mesh surgery or revisions?
A. Correct.
Q. Okay.
A. And it's because she did not have those symptoms supportive of interstitial cystitis before she had the mesh related procedures, period.
Q. In your opinion?
A. In my opinion as a pelvic mesh complication expert, yes.
Q. And it may just be that you and Dr. Pradmudji disagree on that interstitial cystitis

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cause; correct?
A. I believe that Dr. Pradmudji is a -- I believe she hasn't diagnosed Mrs. Huskey with interstitial cystitis either, technically.
Q. It's your belief from reading her deposition and her expert report that what she's saying is that interstitial cystitis has not been ruled out in Ms. Huskey's case?
A. Right. But Mrs. Huskey did not have interstitial cystitis when she had the mesh placed, prior to the mesh placement.
Q. Prior to having the mesh placed, did any of her doctors rule out interstitial cystitis?
A. There would be no reason to. She didn't have the profile of interstitial cystitis. She didn't have six months of persistent urinary symptoms that would lead anyone to pursue that pathway with this patient. At least not a pelvic pain expert.
Q. And you make that statement based upon your review of her records?
A. And my clinical expertise, yes.
Q. Did Mrs. Huskey have vaginal atrophy before her TVT-O placement?
A. She did.

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Q. Is that a common finding in post-menopausal women?
A. It is.
Q. What is chronic vulvitis?
A. It's a local inflammatory condition of the vulva.
Q. What causes that?
A. Could be a variety of things. Usually it's a local irritant. Dry skin. Too much perfume or lotion on the skin. It's usually easily corrected by removing the irritative factor.
Q. Did Mrs. Huskey have chronic vulvitis before the TVT-O?
A. She did.
Q. Vaginitis. That's an infection of the vagina?
A. It's a very common infection of the vagina.
Q. Is it nonspecific to a particular bacteria or organism?
A. There are a couple of primary ones that will cause inflammation of the vagina. They're generally, I mean, easy to treat and resolve quickly to treatment.
Q. Did Mrs. Huskey have vaginitis before

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her TVT-O placement?
A. I believe she was treated prior to her procedure, but most women have had at least one vaginal infection in their lifetime.
Q. Vaginitis is different from urinary tract infection, or can they be the same?
A. No. They're different.
Q. Page 3 and 4 of your report, where you say, "According to Dr. Pradmudji, the pelvic exam findings are minimal."
See that?
A. I do.
Q. All right. Your exam was done about three months before Dr. Pradmudji's exam; correct?
A. Yes. Exactly.
Q. Can there be different findings on different exams by different doctors where those exams are separated by months at a time?
A. While there can be, as we discussed earlier, there can be fluctuation in the patient's pain. You also have to know how to assess the specific muscles of the pelvic floor, as well as attempt to produce the appropriate amount of pressure, as well as -- I'll just leave it at that.
Q. The McGill Pain Questionnaire, that's

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something you've used in the past?
A. It is. Yes.
Q. And that's a questionnaire for assessing chronic pain?
A. It is. We don't have very many. The problem with all of our pain questionnaires -- and this is consistent throughout the literature -- is that they -- even the ones that are designed to evaluate chronic pelvic pain and dyspareunia, they poorly represent the disease process and do not differentiate between the different types of pain.
So it makes it difficult, as a researcher and clinician, to use those regularly because it's not specific enough.
Q. Can that form be helpful in assessing chronic pain in a patient?
A. The only time I would use that form would be if I was introducing an intervention and was assessing baseline levels and post-baseline levels from a research standpoint. But clinically, I do not find it helpful.
Q. Going back to the earlier part of your report where you talk about the posterior muscles of the vagina will react anywhere in the pelvis.
We talked about that a little earlier.

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A. Yes.
Q. Is that specific to only the posterior muscles?
A. Are you referring to number 1?
Q. Yes.
A. And I'm sorry. Can you clarify what you're asking?
Q. When you say, "Posterior muscles will react to pain anywhere in the pelvis," my question is: Is that relationship only found with the posterior muscles or could it be seen with the anterior muscles?
A. No. It's the entire vagina as a whole. So the levator --
Q. So pain from -- okay.
A. No. It's like the pelvic -- the levator complex, the obturator internus, the piriformis. I mean, those are what create our pelvic floor musculature. So irritation of one of those could irritate the other ones, potentially. I mean, the vagina is not a very big space.
Q. Basically the levator spasm, Dr. Pradmudji attributes that to other causes other than the mesh, but you believe it's from the mesh. Is that a fair summary?

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A. Mesh and excision of the mesh, yes.
MR. SNELL: Okay. That's all the questions I have for you. Thank you for your time. I told you I'd get you out of here.
MR. KUNTZ: I have no questions.
(Deposition concluded at 2:46 p.m.)

ERRATA

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ACKNOWLEDGMENT OF DEPONENT

I,_____, do hereby certify that I have read the foregoing pages, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

ERIN T. CAREY, M.D. DATE

Subscribed and sworn to before me this _____ day of _____, 20____.

My commission expires:_____

_____

Notary Public

REPORTER'S CERTIFICATE

I, NAOLA C. VAUGHN, a Certified Court Reporter within and for the States of Missouri and Kansas, hereby certify that the within-named witness was first duly sworn by me to testify to the truth; and that the deposition by said witness was given in response to the questions propounded, as herein set forth; was first taken in machine shorthand by me and afterwards reduced to writing under my direction and supervision; and is a true and correct record of the testimony given by the witness.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorneys or counsel, or financially interested in the action.

WITNESS my hand and official seal at Tonganoxie, Kansas, this 10th day of July 2014.

_____

NAOLA C. VAUGHN, CCR, CRR, RPR
Missouri CCR No. 1052
Kansas CCR No. 0895